

<i>SERFF Tracking Number:</i>	<i>AMFT-126726824</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monitor Life Insurance Company of New York</i>	<i>State Tracking Number:</i>	<i>46430</i>
<i>Company Tracking Number:</i>	<i>ML-POL-DENT (10/05) AR</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>ML-POL-DENT (10/05)/ML-POL-DENT (10/05)</i>		

Filing at a Glance

Company: Monitor Life Insurance Company of New York

Product Name: Group Dental

SERFF Tr Num: AMFT-126726824 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved-
Closed

State Tr Num: 46430

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: ML-POL-DENT (10/05) State Status: Approved-Closed
AR

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Rebecca Ewing

Disposition Date: 08/13/2010

Date Submitted: 08/09/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: ML-POL-DENT (10/05)

Status of Filing in Domicile: Pending

Project Number: ML-POL-DENT (10/05)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 08/13/2010

Explanation for Other Group Market Type:

State Status Changed: 08/13/2010

Deemer Date:

Created By: Rebecca Ewing

Submitted By: Rebecca Ewing

Corresponding Filing Tracking Number:

Filing Description:

Enclosed are the following forms for your review and approval:

Form Number Description

ML-POL-DENT (10/05) Group Dental Master Policy

ML-MCERT-DENT (10/05) Group Dental Certificate for Association Members

ML-ECERT-DENT (10/05) Group Dental Certificate for Employees

ML-DENTAL ER GPAPP(10/05) Group Dental Application

ML-DENTAL ASSOC GPAPP(10/05) Group Dental Application

SERFF Tracking Number: AMFT-126726824 State: Arkansas
 Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
 Company Tracking Number: ML-POL-DENT (10/05) AR
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)
 ML-ALL-STATES-DENTAL-APP-1(10/05) Application/Enrollment Form

The Master Policy will be issued to employers in your state along with the Employee Certificate ML-ECERT-DENT (10/05). The Master Policy will also be issued to eligible associations along with the Member Certificate ML-MCERT-DENT (10/05). Benefits Association, Inc. has been approved and registered in and by the state of Mississippi. World Travelers of America, Inc. has been approved and registered in and by the state of Maryland.

In addition to the above, attached are the following: We have included the following filing materials:

- Filing Authorization Letter
- Readability Certification

If you have any questions, please call me at (972) 850-3272 or email me at rewing@lewisellis.com.

Company and Contact

Filing Contact Information

Ewing Rebecca, Compliance Consultant rewing@lewisellis.com
 P O Box 851857 972-850-3272 [Phone]
 Richardson, TX 75085 972-850-3273 [FAX]

Filing Company Information

Monitor Life Insurance Company of New York	CoCode: 81442	State of Domicile: New York
70 Genesee Street	Group Code:	Company Type: Insurance Company
Utica, NY 13502-3502	Group Name:	State ID Number:
(800) 422-6200 ext. 270[Phone]	FEIN Number: 16-0986348	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Monitor Life Insurance Company of New York	\$50.00	08/09/2010	38607600

<i>SERFF Tracking Number:</i>	<i>AMFT-126726824</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monitor Life Insurance Company of New York</i>	<i>State Tracking Number:</i>	<i>46430</i>
<i>Company Tracking Number:</i>	<i>ML-POL-DENT (10/05) AR</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>ML-POL-DENT (10/05)/ML-POL-DENT (10/05)</i>		
Monitor Life Insurance Company of New York	\$250.00	08/10/2010	38662147

SERFF Tracking Number: AMFT-126726824 State: Arkansas
 Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
 Company Tracking Number: ML-POL-DENT (10/05) AR
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/13/2010	08/13/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	08/11/2010	08/11/2010	Rebecca Ewing	08/12/2010	08/12/2010
Pending Industry Response	Rosalind Minor	08/10/2010	08/10/2010	Rebecca Ewing	08/10/2010	08/10/2010

<i>SERFF Tracking Number:</i>	<i>AMFT-126726824</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monitor Life Insurance Company of New York</i>	<i>State Tracking Number:</i>	<i>46430</i>
<i>Company Tracking Number:</i>	<i>ML-POL-DENT (10/05) AR</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>ML-POL-DENT (10/05)/ML-POL-DENT (10/05)</i>		

Disposition

Disposition Date: 08/13/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMFT-126726824 State: Arkansas

Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430

Company Tracking Number: ML-POL-DENT (10/05) AR

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: Group Dental

Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Filing Authorization Letter	Approved-Closed	Yes
Supporting Document	Prior Approval of Associations	Approved-Closed	Yes
Form (revised)	Group Dental Master Policy	Approved-Closed	Yes
Form	Group Dental Master Policy	Replaced	Yes
Form (revised)	Group Dental Certificate for Association Members	Approved-Closed	Yes
Form	Group Dental Certificate for Association Members	Replaced	Yes
Form (revised)	Group Dental Certificate for Employees	Approved-Closed	Yes
Form	Group Dental Certificate for Employees	Replaced	Yes
Form	Group Dental Application	Approved-Closed	Yes
Form	Group Dental Application	Approved-Closed	Yes
Form	Application/Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: AMFT-126726824 State: Arkansas
Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
Company Tracking Number: ML-POL-DENT (10/05) AR
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/11/2010

Submitted Date 08/11/2010

Respond By Date

Dear Ewing Rebecca,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)
- Group Dental Certificate for Association Members, ML-MCERT-DENT (10/05) (Form)
- Group Dental Certificate for Employees, ML-ECERT-DENT (10/05) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 2

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)
- Group Dental Certificate for Association Members, ML-MCERT-DENT (10/05) (Form)
- Group Dental Certificate for Employees, ML-ECERT-DENT (10/05) (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Objection 3

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)

Comment:

With respect to minors for whom the insured has filed a petition to adopt, your attention is called to the 60-day period outlined under ACA 23-85-137.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: AMFT-126726824 State: Arkansas
Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
Company Tracking Number: ML-POL-DENT (10/05) AR
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/12/2010
Submitted Date 08/12/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter regarding the referenced filing. I am responding to your letter as follows:

Response 1

Comments: The Group Policy and Group Certificates have been revised by removing the time limit set for furnishing proof of incapacity. The form numbers for these forms have been revised by adding "AR" after the form number (s).

Related Objection 1

Applies To:

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)
- Group Dental Certificate for Association Members, ML-MCERT-DENT (10/05) (Form)
- Group Dental Certificate for Employees, ML-ECERT-DENT (10/05) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Dental Master Policy	ML-POL-DENT (10/05)		Policy/Contract/Fraternal Certificate	Initial		50.400	ML-POL-DENT 1005

SERFF Tracking Number: AMFT-126726824 State: Arkansas
Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
Company Tracking Number: ML-POL-DENT (10/05) AR
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

AR

AR.pdf

Previous Version

Group Dental Master Policy	ML-POL-DENT (10/05)	Policy/Contract/Fraternal Certificate	Initial	50.400	ML-POL-DENT 1005.pdf
Group Dental Certificate for Association Members	ML-MCERT-DENT (10/05)	Certificate	Initial		ML-MCERT-DENT 1005 AR.pdf

Previous Version

Group Dental Certificate for Association Members	ML-MCERT-DENT (10/05)	Certificate	Initial		ML-MCERT-DENT 1005.pdf
Group Dental Certificate for Employees	ML-ECERT-DENT (10/05)	Certificate	Initial		ML-ECERT-DENT 1005 AR.pdf

Previous Version

Group Dental Certificate for Employees	ML-ECERT-DENT (10/05)	Certificate	Initial		ML-ECERT-DENT 1005.pdf
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No Rate/Rule Schedule items changed.

Response 2

Comments: The forms have been further revised by adding the following: "Coverage for newborn infants shall be for 90 days."

Related Objection 1

Applies To:

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)
- Group Dental Certificate for Association Members, ML-MCERT-DENT (10/05) (Form)

SERFF Tracking Number: AMFT-126726824 State: Arkansas
 Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
 Company Tracking Number: ML-POL-DENT (10/05) AR
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

- Group Dental Certificate for Employees, ML-ECERT-DENT (10/05) (Form)
 Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Dental Master Policy	ML-POL-DENT (10/05) AR		Policy/Contract/Fraternal Certificate	Initial		50.400	ML-POL-DENT 1005 AR.pdf
Previous Version							
Group Dental Master Policy	ML-POL-DENT (10/05)		Policy/Contract/Fraternal Certificate	Initial		50.400	ML-POL-DENT 1005.pdf
Group Dental Certificate for Association Members	ML-MCERT-DENT (10/05) AR		Certificate	Initial			ML-MCERT-DENT 1005 AR.pdf
Previous Version							
Group Dental Certificate for Association Members	ML-MCERT-DENT (10/05)		Certificate	Initial			ML-MCERT-DENT 1005.pdf
Group Dental Certificate for Employees	ML-ECERT-DENT		Certificate	Initial			ML-ECERT-DENT

<i>SERFF Tracking Number:</i>	<i>AMFT-126726824</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monitor Life Insurance Company of New York</i>	<i>State Tracking Number:</i>	<i>46430</i>
<i>Company Tracking Number:</i>	<i>ML-POL-DENT (10/05) AR</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>ML-POL-DENT (10/05)/ML-POL-DENT (10/05)</i>		
	<i>(10/05)</i>		<i>1005</i>
	<i>AR</i>		<i>AR.pdf</i>

Previous Version

<i>Group Dental</i>	<i>ML-</i>	<i>Certificate</i>	<i>Initial</i>	<i>ML-</i>
<i>Certificate for</i>	<i>ECERT-</i>			<i>ECERT-</i>
<i>Employees</i>	<i>DENT</i>			<i>DENT</i>
	<i>(10/05)</i>			<i>1005.pdf</i>

No Rate/Rule Schedule items changed.

Response 3

Comments: The following language has been added regarding adopted children: "Coverage for adopted children shall include coverage for any minor under the charge, care, and control of the Insured whom the Insured has filed a petition to adopt. The coverage shall begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, such coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage required by this provision shall terminate upon the dismissal or denial of a petition for adoption."

Related Objection 1

Applies To:

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)

Comment:

With respect to minors for whom the insured has filed a petition to adopt, your attention is called to the 60-day period outlined under ACA 23-85-137.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Dental Master Policy	ML-POL-DENT		Policy/Contract/Fraternal Certificate	Initial		50.400	ML-POL-DENT

<i>SERFF Tracking Number:</i>	<i>AMFT-126726824</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Monitor Life Insurance Company of New York</i>	<i>State Tracking Number:</i>	<i>46430</i>
<i>Company Tracking Number:</i>	<i>ML-POL-DENT (10/05) AR</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>Group Dental</i>		
<i>Project Name/Number:</i>	<i>ML-POL-DENT (10/05)/ML-POL-DENT (10/05)</i>		
	<i>(10/05)</i>		<i>1005</i>
	<i>AR</i>		<i>AR.pdf</i>
 <i>Previous Version</i>			
<i>Group Dental Master</i>	<i>ML-POL-</i>	<i>Policy/Contract/Fraternal Initial</i>	<i>50.400</i>
<i>Policy</i>	<i>DENT</i>	<i>Certificate</i>	
	<i>(10/05)</i>		<i>ML-POL-DENT 1005.pdf</i>

No Rate/Rule Schedule items changed.

In addition to the above changes, the following language has been added regarding the time of payment of claims: "The Company shall pay or deny a clean claim within 30 days after receipt by the Company if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means."

Thank you for your continued review of this filing. I trust these forms are now acceptable to you.

Sincerely,
Rebecca Ewing

Sincerely,
Rebecca Ewing

SERFF Tracking Number: AMFT-126726824 State: Arkansas
Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
Company Tracking Number: ML-POL-DENT (10/05) AR
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 08/10/2010

Submitted Date 08/10/2010

Respond By Date

Dear Ewing Rebecca,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)
- Group Dental Certificate for Association Members, ML-MCERT-DENT (10/05) (Form)
- Group Dental Certificate for Employees, ML-ECERT-DENT (10/05) (Form)
- Group Dental Application, ML-DENTAL ER GPAPP(10/05) (Form)
- Group Dental Application, ML-DENTAL ASSOC GPAPP(10/05) (Form)
- Application/Enrollment Form, ML-ALL-STATES-DENTAL-APP-1(10/05) (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$300.00. Please submit an additional \$250.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: AMFT-126726824 State: Arkansas
Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
Company Tracking Number: ML-POL-DENT (10/05) AR
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/10/2010
Submitted Date 08/10/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter regarding the referenced filing.

Response 1

Comments: An additional filing fee in the amount of \$250.00 has been submitted to you via EFT.

Related Objection 1

Applies To:

- Group Dental Master Policy, ML-POL-DENT (10/05) (Form)
- Group Dental Certificate for Association Members, ML-MCERT-DENT (10/05) (Form)
- Group Dental Certificate for Employees, ML-ECERT-DENT (10/05) (Form)
- Group Dental Application, ML-DENTAL ER GPAPP(10/05) (Form)
- Group Dental Application, ML-DENTAL ASSOC GPAPP(10/05) (Form)
- Application/Enrollment Form, ML-ALL-STATES-DENTAL-APP-1(10/05) (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$300.00. Please submit an additional \$250.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

SERFF Tracking Number: *AMFT-126726824* *State:* *Arkansas*
Filing Company: *Monitor Life Insurance Company of New York* *State Tracking Number:* *46430*
Company Tracking Number: *ML-POL-DENT (10/05) AR*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *Group Dental*
Project Name/Number: *ML-POL-DENT (10/05)/ML-POL-DENT (10/05)*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing.

Rebecca Ewing

Sincerely,
Rebecca Ewing

SERFF Tracking Number: AMFT-126726824 State: Arkansas
 Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430
 Company Tracking Number: ML-POL-DENT (10/05) AR
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Form Schedule

Lead Form Number: ML-POL-DENT (10/05)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/13/2010	ML-POL-DENT (10/05) AR	Policy/Cont ract/Fratern Certificate	Group Dental Master Initial	Initial		50.400	ML-POL-DENT 1005 AR.pdf
Approved-Closed 08/13/2010	ML-MCERT-DENT (10/05) AR	Certificate	Group Dental Certificate for Association Members	Initial			ML-MCERT-DENT 1005 AR.pdf
Approved-Closed 08/13/2010	ML-ECERT-DENT (10/05) AR	Certificate	Group Dental Certificate for Employees	Initial			ML-ECERT-DENT 1005 AR.pdf
Approved-Closed 08/13/2010	ML-DENTAL ER GPAPP(10/05)	Application/ Enrollment Form	Group Dental Application	Initial			ML-DENTAL ER GPAPP _10 05_.pdf
Approved-Closed 08/13/2010	ML-DENTAL ASSOC GPAPP(10/05)	Application/ Enrollment Form	Group Dental Application	Initial			ML-DENTAL ASSOC GPAPP _10 05_.pdf
Approved-Closed 08/13/2010	ML-ALL-STATES-DENTAL-APP-1(10/05)	Application/ Enrollment Form	Application/ Enrollment Form	Initial			ML-All-States-Dental-App-1 (10 05).pdf

Monitor Life Insurance Company of New York

**70 Genesee Street
Utica, New York 13502
Telephone (800)422-6200**

(Herein called the Company)

Acknowledgment of Application for Group Dental Insurance Contract

Dental Care Plan

[Doe & Doe, LTD], has applied for a Group Dental Insurance Contract with **Monitor Life Insurance Company of New York** ("Monitor"). A copy of the application is attached to this contract. The following terms will apply:

- I. Applicant shall pay Monitor the monthly Premium stated in the Contract.
- II. Monitor has accepted the Application submitted by the Applicant and when Applicant pays the first month's Premium, the term of the Contract shall begin at 12:01 a.m., on the Effective Date listed in Appendix A. The term of the Contract shall end as stated in the Contract at the end of the Contract Term at 12:00 midnight Standard Time.
- III. Applicant shall give each Primary Enrollee a certificate furnished by Monitor. Applicant shall also distribute to its Enrollees any notice from Monitor which affects their rights under the Contract.

**Notice: The premium under this contract is payable to
Monitor Life Insurance Company of New York
Attention: Morgan White Administrators
P. O. Box 16708
Jackson, Mississippi 39236**

The premium under this contract may be increased upon renewal after the end of the initial or any subsequent contract terms.

Monitor Life Insurance Company of New York (“Monitor”) accepts the Application of “Applicant.” A copy is attached and made a part of this Contract. So long as Applicant pays the Premiums stated in Article 3, Monitor agrees to provide the Benefits described in Article 4. Benefits will start at 12:01 a.m. Standard Time on the Effective Date. This Contract will continue from year to year until terminated, as stated in Article 8.

This Contract is issued and delivered in the **State of [New York]** and is governed by its laws.

IN WITNESS WHEREOF Monitor Life Insurance Company of New York has caused this Policy/Certificate to be executed and to take effect on the Effective Date.

Secretary

President

Table of Contents

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Article 1 Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

- 1.01 **“Applicant”** – the employer, association or other organization or group contracting to obtain Benefits.
- 1.02 **“Approved Amount”** – the total fee chargeable for a Single Procedure.
- 1.03 **“Attending Dentist’s Statement”** – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.
- 1.04 **“Benefits”** – the amounts that Monitor will pay for dental services under Article 4.
- 1.05 **“Calendar Year”** – the 12 months of the year from January 1 through December 31.
- 1.06 **“Contract”** – this agreement between Monitor and Applicant, including the Application and the attachments listed in Article 9.
- 1.07 **“Contract Allowance”** – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist’s submitted fee, and the Scheduled Maximum, if any, and the Dentist’s fee filed with Monitor in the Participating Dentist Agreement, if any, or the UCR.
- 1.08 **“Contract Term”** – the period during which the Contract is in effect, as shown in Appendix A.
- 1.09 **“Contract Year”** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and maximums will be determined using this 12 month period rather than on a calendar year basis.
- 1.10 **“Dentist”** – a person licensed to practice dentistry when and where services are performed.
- 1.11 **“Dependent Enrollee”** – an Eligible Dependent enrolled in the plan to receive Benefits.
- 1.12 **“Effective Date”** – the date the program starts, as shown in Appendix A.
- 1.13 **“Eligible Dependent”** – a dependent of an Eligible Person eligible for Benefits under Article 2.

- 1.14 **“Eligible Person”** – a person as listed in Appendix A, designated by the Applicant as eligible for Benefits under Article 2.
- 1.15 **“Enrollee”** – an Eligible Person (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.
- 1.16 **“Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist”** – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. A Non-Participating Dentist may charge more than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.
- 1.17 **“Open Enrollment Period”** – the month(s) of the year, as shown in Appendix A, during which Eligible Persons may change coverage for the next Contract Year.
- 1.18 **“Predetermination”** – Monitor shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.
- 1.19 **“Preferred, Network, Contracting, Participating Dentist”** – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. See Non-Participating Dentist.
- 1.20 **“Premiums”** – the amounts payable monthly by the Applicant as required in the Contract.
- 1.21 **“Primary Enrollee”** – an Eligible Person enrolled in the plan to receive Benefits.
- 1.22 **“Procedure Number”** – the number given to a Single Procedure in the Monitor Dental Uniform Procedure Code and Nomenclature attached as Appendix B.
- 1.23 **“Qualifying Family Status Change”** – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.

- 1.24 **“Scheduled Maximum”** – the maximum Contract Allowance for each dental procedure, as shown in Appendix B, if any.
- 1.25 **“Single Procedure”** – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).
- 1.26 **“UCR”** – “usual, customary and reasonable” which have the following meanings:

Usual – A “usual” fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is “customary” when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic areas determined by Monitor to be relevant. Customary fees may be determined on the basis of fees filed with Monitor by Participating Dentist. A Customary fee for a Participating Dentist is that fee which is approved by Monitor in the terms of the Participating Dentist Agreement.

Reasonable – A fee is “reasonable” if it is “usual” and “customary” or if it falls above “usual” and “customary” or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

- 1.27 **“Uniform Procedure Code”** – the Monitor Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.
- 1.28 **“We, Our, or Us”** – Monitor, and will be used without respect to capitalization.
- 1.29 **“You, Your, Yours”** – the Primary Enrollee and will be used without respect to capitalization.

Article 2 Eligibility and Enrollment

- 2.01 **Reporting** Applicant shall furnish to Monitor on or before the Effective Date, and by the first day of every month, a list of all Primary Enrollees. The list must show their Social Security numbers, dates of [hire] and location codes, if any. Monitor shall not pay Benefits for any Enrollee or any dependents if the Enrollee is not on the list of Primary Enrollees. Nor will Monitor pay Benefits for an Enrollee if the Premium has not been paid for the month when the dental services are performed. However, a child shall be covered for 31 days

after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

- 2.02 Applicant shall permit Monitor to audit Applicant's records to check whether the lists of Primary Enrollees are correct and to confirm compliance with Article 3. Monitor shall give Applicant written notice within a reasonable time before the audit date.

- 2.03 **Eligible Persons** Eligible Persons are:

All present and future permanent [employees of Applicant working full-time the minimum number of hours shown in Appendix A] shall become eligible on the calendar day shown in Appendix A of the month after they have [worked full-time for the minimum number of months shown as the Eligibility Period in Appendix A].

- 2.04 **Eligible Dependents** Eligible Dependents of an Eligible Person are:

- a) Lawful spouse.
- b) An unmarried child from birth to the 19th birthday, or 25th birthday if a full-time student in an accredited school. "Children" include natural children, stepchildren, adopted children and foster children. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the point of placement in the physical custody of the Eligible Person, as certified by the agency-making placement.
- c) An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 19 and the child is mostly dependent on the Eligible Person for support and maintenance. Proof of these facts must be given to Monitor or the Applicant if it is requested. Proof shall not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

- 2.05 **Enrollment of Eligible Persons and Eligible Dependents**

- a) If Applicant pays the entire cost of coverage, all Eligible Persons and Eligible Dependents are Enrollees covered under the plan. Coverage cannot be waived.
- b) If an Eligible Person must contribute any portion of the cost of coverage, Eligible Persons and their Eligible Dependents must enroll to be covered

under the plan. Enrollment must be within 30 days after first becoming eligible or during an Open Enrollment Period. Coverage may not be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Family Status Change.

- c) The Primary Enrollee pays the cost of coverage, by the method elected by the applicant, for Dependent Enrollees until they are no longer dependents or until the Primary Enrollee chooses to drop coverage. Coverage may not be changed or dropped at any time other than during an Open Enrollment Period or because of a Qualifying Family Status Change.
 - d) If both spouses are Eligible Persons, one may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.
 - e) If the Primary Enrollee enrolls any dependent for dependent coverage, all Eligible Dependents must be enrolled as Dependent Enrollees.
- 2.06 If the Applicant is a Primary Enrollee's employer, then except for an employee absent from work due to a leave of absence governed by the "Family Medical Leave Act of 1993" (P.L. 103.3), an Enrollee shall not be covered for any dental services received while a Primary Enrollee is on strike, lay-off or leave of absence. Applicant must inform Monitor of any change in eligibility as required under Section 2.01.

Coverage shall resume on the first day of the month after the Primary Enrollee returns to work. Such Primary Enrollees shall be considered as newly hired employees with respect to the application of deductibles and maximums when they return to work. If an absence exceeds six (6) months, then such Primary Enrollees shall be considered newly hired employees in every respect and must fulfill the eligibility requirements.

- 2.07 A Primary Enrollee loses coverage on the last day of the month of employment or on the day the Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee, or earlier if dependent status is lost.

Coverage for newborn infants shall be for 90 days.

Coverage for adopted children shall include coverage for any minor under the charge, care, and control of the Insured whom the Insured has filed a petition to adopt. The coverage shall begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, such coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after

the birth of the minor. The coverage required by this provision shall terminate upon the dismissal or denial of a petition for adoption.

Article 3 Monthly Premiums

- 3.01 Applicant shall remit the monthly Premium in the amount and manner shown in Appendix A for all Primary Enrollees and Dependent Enrollees to:

Monitor Life Insurance Company of New York
Attention: Membership Services
P. O. Box 16708
Jackson, Mississippi 39236

- 3.02 This Contract shall not be in effect until Monitor receives the first month's Premiums. Subsequent Premiums shall be paid by the first day of each month. For each Premium after the first, a grace period of 30 days from the due date will be allowed for the payment of Premium. The Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, Monitor may terminate the Contract as of the due date in accordance with the notice requirements of Section 8.01.
- 3.03 If this Contract is terminated before the end of a Contract Term, Applicant shall pay additional charges in accordance with Article 8.
- 3.04 Monitor may change the rate of monthly Premium whenever the Contract is amended. Any change in Premium shall not be effective during a Contract Term unless Applicant and Monitor agree in writing, except as provided in 3.06 below.
- 3.05 Premiums are based on the number of covered Primary Enrollees. If the Applicant reports a difference in the number of covered Primary Enrollees, as shown in Appendix A, for three months in a row, Monitor may propose a choice of change in Premiums or Benefits to remedy the increase in cost per person which may result from fewer enrolled Primary Enrollees. Within 30 days, Applicant shall select one of the choices by written notice to Monitor. If Applicant fails to do so, Monitor may select one of the choices by written notice to Applicant. The Contract shall be modified for dental services Predetermined and paid after notice.
- 3.06 If, during the Contract Term, any new or increased tax is imposed on the amounts payable to Monitor under this Contract, the amount stated in Section 3.01 shall be increased by the amount of any such new or increased taxes.

Article 4 Benefits, Limitations and Exclusions

- 4.01 Subject to the limitations and exclusions in this Contract, Monitor shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. Monitor may use dental consultants to determine generally accepted dental practice standards. Waiting periods, if any, for specific services are shown in Appendix A.
- 4.02 **Patient Copayment** Monitor's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Appendix A. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Monitor shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.
- 4.03 **Limitations on All Benefits – Optional Services** Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- 4.04 No change in Benefits will become effective during a Contract Term unless Applicant and Monitor agree in writing.
- 4.05 **Exclusions** Monitor does not pay Benefits for:
- a) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
 - b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).

- c) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.
- d) Any Single Procedure started before the patient is covered under this program.
- e) Prescribed drugs, medication or painkillers.
- f) Experimental procedures.
- g) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) Services for any disturbance of the temporomandibular joints (jaw joints).
- k) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- l) For services provided outside the United States, its territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.
- m) The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under this dental plan.

4.06 Diagnostic and Preventive Benefits (Type I Procedures) Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal scaling in the presence of inflamed gums is considered to be a Basic Service for payment provisions); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used

to seal developmental grooves and pits in teeth for the purpose of preventing decay).

4.07 Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

- a) Monitor will not pay for more than one (1) cleaning, including periodontal cleanings, done in any six (6) month period that the Enrollee is covered by any Monitor program.
- b) Monitor will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any Monitor program.
- c) Full-mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but no more than one set each 36 month period will be paid by Monitor.
- d) Bitewing x-rays are limited to one set each 12 month period.
- e) Topical applications of fluoride are limited to one each 12 month period when provided to Enrollees under age 19; furthermore, Monitor will not pay for topical application of fluoride for an Enrollee 19 years or older.
- f) Sealant applications to any one posterior permanent tooth are limited to one each 36 month period.

4.08 Basic Benefits (Type II Procedures) Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Preventative:	space maintainers.
[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Restorative:	Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services.
Palliative:	treatment to relieve pain.

- 4.09 **Limitations on Basic Benefits (Type II Procedures)** Monitor will not pay for space maintainers for baby teeth for an Enrollee 16 years or older.

4.10 **Major Benefits (Type III Procedures)** Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

[**Oral Surgery:** extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]

[**Endodontics:** pulp capping, pulpotomy, root canal therapy, and periapical services.]

[**Periodontics:** surgical services (including unusual postoperative services) and adjunctive periodontal services.]

Prosthodontics: Complete & partial dentures (including routine post delivery care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.

Orthodontics: The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

4.11 **Limitations on Prosthodontic Benefits**

- a) The maximum amount paid by Monitor for each Enrollee during the Contract Year is shown in Appendix A.
- b) Monitor will not pay to replace any crown, jacket or cast restoration that the patient received in the previous 5 years.
- c) Monitor will not pay to replace any bridge or denture that the patient received in the previous 5 years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
- d) Monitor limits Benefits for dentures to a standard partial or complete denture. A “standard” denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- e) Monitor will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Monitor will credit the cost of a standard complete or partial denture that would have been allowed under

this plan toward the cost of an implant and related services (copayments apply.)

4.12 Limitations on Orthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the Contract Year and the Enrollee's lifetime is shown in Appendix A.
- b) Payment of Orthodontics is provided monthly.
- c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.
- e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.
- f) X-rays or extractions are not subject to the Orthodontic maximum.
- g) Surgical procedures are not subject to the Orthodontic maximum.
- h) Orthodontic Benefits are limited to Dependent Enrollees within ages shown in Appendix A.
- i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for [12] consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant's previous plan.

Article 5 Deductible, Maximum and Coordination of Benefits

- 5.01 **Deductible** Monitor will not pay Benefits for the deductible amount shown in Appendix A of the Dentist's UCR fees for services received [for the term of the Enrollee's policy contract or per contract year]. Services, to which a deductible is **not** applied, if any, are shown in Appendix A. Only fees an Enrollee pays for services that are described under Article 4 shall count toward the deductible.
- 5.02 **Maximum** Monitor shall pay a maximum amount shown in Appendix A each [Contract Year] per Enrollee for all Benefits as listed.
- 5.03 **Coordination of Benefits** Monitor coordinates the Benefits under this Contract with an Enrollee's benefits under any other group pre-paid program

or insurance policy. Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's total fees for covered services. If this is the "primary" program, Monitor shall not reduce Benefits. But if the other program is the primary one, Monitor shall reduce Benefits otherwise payable under this Contract. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under Article 4.

The following rules determine which is the "primary" program:

- a) If the other program is not primarily a dental program, this program is primary.
- b) If the other program is a dental program, the following rules are applied:
 - 1. The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
 - 2. The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.
- c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Article 6 Conditions Under Which Benefits Shall Be Provided.

- 6.01 **Choice of a Dentist** An Enrollee may choose any Dentist, but Monitor does not guarantee that any particular Dentist shall be available. The Enrollee is responsible for verifying whether the treating Dentist is a Participating

Dentist, if necessary. A directory of Participating Dentist will be provided to the Applicant, if necessary.

- 6.02 **Clinical Examination** Before approving a claim, Monitor may obtain, to such extent as may be lawful, from any Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to an Enrollee as Monitor may require to administer the claim. Or Monitor may require that an Enrollee be examined by a dental consultant retained by Monitor in or near his community or residence. Such information and records shall be kept confidential.
- 6.03 **Notice of Claim Forms** Monitor shall furnish to any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for payment of Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Monitor at the address shown thereon. If Monitor does not furnish the form within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in Section 6.05 of this Contract shall be deemed to have been complied with upon the submission to Monitor, within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made, within the time established in said section for filing proof of loss.
- 6.04 **Predetermination** A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. Monitor shall predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term nor beyond the date the patient's coverage ends.
- 6.05 **Proof of Loss** Affirmative proof of loss must be furnished to Monitor at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of loss within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss within such time and that such proof of loss was furnished as soon as reasonably possible.
- 6.06 **Time of Payment** Indemnities payable under this Contract for any loss other than loss for which this Contract provides any periodic payment shall be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment shall be paid monthly and any balance remaining upon the termination of liability shall be paid immediately upon receipt of due written proof. Claims not paid within forty-five (45) days of due written proof of loss are subject to a charge of 1 and ½ percent interest per month.

The Company shall pay or deny a clean claim within 30 days after receipt by the Company if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.

- 6.07 **Review of Claim Denial** Monitor shall notify the Primary Enrollee if any Benefits are denied for services submitted on an Attending Dentist's Statement under Section 6.03, stating the reason(s) for denial. An Enrollee has 60 days after receiving a notice of denial to appeal it by writing to Monitor giving reasons why the denial was wrong. The Enrollee may also ask Monitor to examine any records to aid his appeal.

Monitor shall make a full and fair review. Monitor may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of the local dental society in the patient's area. A decision shall be sent to the Primary Enrollee within 30 days after Monitor receives the request for appeal, unless it is referred to a peer review committee or other unusual circumstances arise. In no event shall the decision take longer than 120 days.

- 6.08 **Termination of Benefits on Loss of Eligibility** Monitor shall not pay for Benefits for any services received by a patient who is not an Enrollee at the time of treatment except for Single Procedures started when the patient was covered. Applicant shall reimburse Monitor for any payments made because of errors in Applicant's reports under Section 2.01.

- 6.09 **To Whom Benefits Are Paid** Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him.

Article 7 General Contract Provisions

- 7.01 **Contract Changes** This Contract, including the Application and the attachments listed in Article 9, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract shall be valid unless approved by an executive officer of Monitor.
- 7.02 **Severability** If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract shall remain in full force and effect.

- 7.03 **Conformity With State Laws** All legal questions about this Contract shall be governed by the State of [New York] where the Contract was entered into and is to be performed. Any part of this Contract which, on its Effective Date, conflicts with the laws of [New York] hereby amended to conform to the minimum requirements of such laws.
- 7.04 **Effect of Misstatements on Application** In the absence of fraud, all statements made by the Applicant or Enrollee shall be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Applicant or Enrollee, a copy of which has been furnished to such Applicant or Enrollee.
- 7.05 **Legal Actions** No action at law or in equity shall be brought to recover on this Contract before 60 days after proof of loss has been filed in accordance with requirements of this Contract; nor shall an action be brought at all unless brought within three (3) years after expiration of the time within which proof of loss is required by this Contract.
- 7.06 **Not in Lieu of Workers' Compensation** This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.
- 7.07 **Certificate of Insurance** Monitor shall issue to the Applicant for delivery to each Primary Enrollee a certificate summarizing the Benefits to which they are entitled and to whom Benefits are payable. The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract shall materially affect any Benefits described in the certificate, new certificates or riders showing the change shall be issued.
- 7.08 **Publications About Program** Applicant and Monitor agree to consult as is reasonable practical on all material published or distributed about this Contract. No material shall be published or distributed which conflicts with the terms of this Contract.
- 7.09 **Professional Relationship** Applicant and Monitor agree to permit and encourage the professional relationship between Dentist and patient to be maintained without interference.
- 7.10 **Notice; Where Directed** All formal notice under this Contract must be in writing and sent by first-class United States mail, overnight delivery service, or person delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.
- 7.11 **Indemnification** Applicant shall indemnify, defend and hold harmless Monitor, its directors, officers, employees, agents and affiliated companies

against any and all claims, demands liabilities, costs damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Applicant's negligent performance or non-performance of its obligations under this Agreement.

Monitor shall indemnify, defend and hold harmless Applicant and its employees, members and agents, against any and all claims demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Monitor's negligent performance or non-performance of its obligations under this Agreement.

Article 8 Terminations, Renewal and Continuation

8.01 This Contract may be terminated only as follows:

- a) By Applicant or Monitor, at the end of a Contract Term upon 60 days written notice. If Monitor desires to change Premiums or Benefits at the end of a Contract Term, it shall give Applicant 60 days written notice, which shall terminate the Contract unless amended by mutual consent.
- b) By Monitor
 - (i) Upon 30 days written notice if Applicant fails to furnish Monitor a list of all Enrollees as required under Section 2.01; or
 - (ii) Upon 30 days written notice if Applicant fails to permit Monitor to inspect Applicant's records as called for under Section 2.01; or
 - (iii) Upon 30 days written notice if Applicant fails to pay or remit (if plan is voluntary) Premiums, in the amount and manner required by Article 3.
- c) By Monitor, if Applicant reports fewer than the Minimum Number of Primary Enrollees shown in Appendix A for three (3) consecutive months. Monitor must give Applicant notice within 15 days after receiving the list of Primary Enrollees, which shows that Monitor may terminate on this basis.

8.02 If the Contract is terminated under Section 8.01 (b), Applicant shall owe Monitor the greater of:

- a) All unpaid Premiums due before the Contract was terminated, or
- b) $A \text{ plus } B \text{ minus } C$ where

A equals all Benefits paid during the Current Contract Term before the Contract was terminated,

B equals 25% of A to compensate Monitor for its costs of operating the program, and

C equals any Premiums in fact paid by Applicant during the Contract Term.

- [8.03 If applicant notifies Monitor that it intends to terminate the Contract on any day other than the final day of the Contract Term, Section 8.02 shall apply as if Monitor terminated the Contract under Section 8.01 (b) because Applicant failed to pay Premiums.]
- 8.04 Monitor shall not be required to Predetermine services if the Contract is terminated for any cause nor shall Monitor be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while the contract was in effect.
- 8.05 **Continuation of Coverage under COBRA** When the Eligible Persons of an Applicant are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the payments specified in Article 3 Monitor agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this provision.
- a) For purposes of this provision, each of the following shall constitute a "Qualifying Event":
- (1) Termination of a Primary Enrollee's employment with Applicant (other than for gross misconduct), or a reduction in the number of hours worked by the Primary Enrollee to less than the minimum number of hours required.
 - (2) Death of a Primary Enrollee.
 - (3) Divorce or legal separation from a Primary Enrollee.
 - (4) A Primary Enrollee becoming entitled to Medicare benefits.
 - (5) A dependent child ceasing to meet the description of dependent child.
 - (6) A bankruptcy proceeding under Title 11, United States Code with respect to the Applicant, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee

(who retired on or before the date of substantial elimination of coverage), or of the Dependent Enrollees of a retired Primary Enrollee.

- b) Primary Enrollees or Dependent Enrollees whose coverage under this program is terminated by reason of a Qualifying Event described in Section (a) (1) of this provision may elect to continue coverage for 18 months following the month in which the Qualifying Event occurs, or for 29 months following the month in which the Qualifying Event occurs in the case of Primary Enrollees or Dependent Enrollees who are determined under Title II or XVI of the Social Security Act to have been disabled at the time the Qualifying Event occurs, provided notice of such determination is given to Monitor during the initial 18 months and within 60 days after the date of the determination, and provided further that extended coverage for disability terminates the month that begins more than 30 days after the date of the final determination that the person is no longer disabled.
- c) Dependent Enrollees whose coverage under this program is terminated by reason of any of the Qualifying Events described in Section (a) (2) through (5) of this provision may elect to continue their coverage for 36 months following the month in which the Qualifying Event occurs. However, persons who elect to continue their coverage based on a Qualifying Event described in Section (a) (1) of this provision, and for whom a second Qualifying Event described in Section (a) (2) through (5) of this provision occurs within the next 18 months, may elect to continue their coverage for a maximum of 36 months following the month in which the first Qualifying Event occurred (in the case of a second Qualifying Event described in Section (2), (3) or (5), or for a maximum of 36 months following the month in which the second Qualifying Event occurred (in the case of a Qualifying event described in Section (a) (4)).
- d) Primary Enrollees or Dependent Enrollees whose coverage under this program is terminated by reason of a Qualifying Event described in Section (a) (6) of this provision may elect to continue their coverage for 36 months after the date of death of the retired Primary Enrollee (in the case of Dependent Enrollees of a retired Primary Enrollee).
- e) Continued coverage can be elected only by notice to Applicant, which must be given no later than 60 days after the a termination of coverage by reason of a Qualifying Event, or within 60 days after the Enrollee receives from Applicant a notice about his or her rights to continued coverage because of the particular Qualifying Event, whichever is later. Persons for whom a Qualifying Event described in Section (a) (3) or (5) occurs must report it to Applicant within 60 days, or lose their right to elect continued coverage.

- f) Continued coverage elected by a person under this provision shall be effective as of the first day of the month following the applicable Qualifying Event described in Section 1 above. However, Benefits shall not be available to a person electing continuing coverage until Monitor receives the data about such person required in the Contract, along with all Premiums then currently payable for such person. Monitor shall not, in any event, make Benefits available under this provision with respect to any person for whom such information and Premiums are not received by Monitor within sixty 60 days after the date such person is required by section (e) of this provision to notify Applicant of his or her election.
- g) Continued coverage for persons under this provisions shall be the same as the coverage for similarly situated Enrollees under the Contract, and if coverage is modified for such Enrollees it shall also be modified in the same manner for persons having continued coverage under this provision.
- h) A person's continued coverage elected under sections b, c or d of this provision shall terminate on the last day of the month in which any of the following events first occurs:
 - (1) The period of continued coverage specified in section b, c or d expires.
 - (2) This Contract terminates.
 - (3) Applicant fails to pay Premiums for the person as specified in Article 3 of the Contract.
 - (4) The person with continued coverage becomes covered for dental benefits under another group health plan (as an employee, member or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such person.
 - (5) The person becomes eligible for Medicare benefits.
- i) Once continued coverage under this provision is terminated, it cannot be reinstated.

Article 9 Attachments

These documents are attached to this Contract and made a part of it:

Appendix A Group Variables

[Appendix B Monitor Uniform Procedure Code and Nomenclature]

Copy of the Application

Appendix A Group Variables

Applicant Name: [Doe & Doe, Ltd.]

Address: [P. O. Box 14000]
[Jackson, Mississippi 39236]

Group Number: [25-1271]

Effective Date: [January 1, 2011]

Contract Term: [January 1, 2011 through December 31, 2011]

Minimum Number of Hours: [20 hours per week]

Eligibility Period: [Three (3) months]

Effective Day of Month: [First day of the month following completion of eligibility]

Open Enrollment Period: [January]

Premiums

Monthly Amount:

For each Primary Enrollee: [\$19.87]

For each Primary Enrollee with
One Dependent Enrollee: [\$39.71]

For each Primary Enrollee with more than
One Dependent Enrollee: [\$59.73]

Payment Breakdown:

Primary Enrollee shall pay [100%] of Premiums for personal coverage. Primary Enrollee shall pay [100%] of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits:

	Policy Year		
	1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	[80%]	[90%]	[100%]
Type II Procedures (Basic Benefits)			
Preventative	[60%]	[70%]	[80%]
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Restorative	[60%]	[70%]	[80%]
Palliative	[60%]	[70%]	[80%]
Type III Procedures			
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Prosthodontics (Removable & Fixed)	[0%]	[40%]	[50%]
Orthodontics	[0%]	[40%]	[50%]

These percentages are based on the Contract Allowance.

Note – Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

Waiting Periods:

Type I Procedures	[0 months]
Type II Procedures	[0 months]
Type III Procedures	[12 months]

Orthodontic Benefits are limited to Dependent Enrollee children 6 years to age 19.

Deductible Amount

For each Enrollee	[\$100.00 for the term of each Enrollee's policy per [Contract Year]]
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Any deductible for Orthodontic Benefits an Enrollee satisfied under the Applicant's prior plan will be credited toward the deductible under this plan.

Maximum Amount:

- [\$600.00] per Enrollee per [Contract Year] for Prosthodontic Benefits.
- [\$350.00] per Enrollee per [Contract Year] for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per Lifetime for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per [Contract Year] for All Benefits (Type I, II, & III Combined).
- [\$500.00] per Enrollee age 65 or older per [Calendar Year] for Prosthetics or the repair thereof.]

Monitor will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination:

Less than [Ten(10)] Primary Enrollee(s).

State of Issue: [New York]

APPENDIX B

MONITOR UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a Complete list of the dental procedures for which benefits are payable under this policy and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120	Periodic oral examination.	\$	[21]
0130	Emergency oral examination.		[21]

Radiographs

0210	Intraoral - complete series (including bitewings).		[50]
0220	Intraoral periapical - first film.		[10]
0230	Intraoral periapical - each additional film up to 12.		[6]
0240	Intraoral - occlusal film.		[11]
0250	Extraoral - first film.		[10]
0260	Extraoral - each additional film.		[13]
0270	Bitewing - single films.		[12]
0272	Bitewings - two films.		[16]
0274	Bitewings - four films.		[22]
0330	Panographic film.		[44]

Tests and Laboratory Examinations

0470	Diagnostic cast.		[40]
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Preventive

Dental Prophylaxis

1110	Prophylaxis - adult.		[32]
1120	Prophylaxis - child.		[26]

Topical Fluoride Treatment (Office Procedure)

1201	Topical application of fluoride (including prophylaxis) - child.		[38]
1202	Topical application of fluoride (including prophylaxis) - adult.		[44]
1203	Topical application of fluoride (excluding prophylaxis) - child.		[13]
1204	Topical application of fluoride (excluding prophylaxis) - adult.		[13]

Other Preventive Services

1351	Sealant - per tooth.		[16]
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BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510	Space Maintainer - fixed unilateral.	\$	[131]
1515	Space Maintainer - fixed-bilateral.		[231]
1520	Space Maintainer - removable-unilateral.		[170]
1525	Space Maintainer - removable-bilateral.		[200]
1550	Recementation of space maintainer.		[32]

Restorative

Amalgam Restorations (including Polishing)

2110	Amalgam - one surface, primary.		[34]
2120	Amalgam - two surfaces, primary.		[43]
2130	Amalgam - three surfaces, primary.		[54]
2140	Amalgam - one surface, permanent.		[32]
2150	Amalgam - two surfaces, permanent.		[42]
2160	Amalgam - three surfaces, permanent.		[53]

Silicate Restorations

2210	Silicate cement - per restoration.		[21]
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Filled or Unfilled Resin Restorations

2310	Acrylic or plastic.		[30]
2330	Resin - one surface.		[37]
2331	Resin - two surface.		[47]
2332	Resin - three surfaces.		[58]

Other Restorative Services.

2940	Sedative filling.		[34]
2950	Crown buildup - pin retained.		[84]
2951	Pin retention - per tooth, in addition to restoration.		[19]
2953	Cast post as part of crown.		[144]
2954	Prefabricated post and core in addition to crown.		[125]
2970	Temporary (fractured tooth).		[84]

[Oral Surgery]

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.		[38]
7120	Each additional tooth.		[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.		[76]
7220	Removal of impacted tooth - soft tissue.		[109]
7230	Removal of impacted tooth - partially bony.		[153]
7240	Removal of impacted tooth - completely bony.	\$	[184]

Other Surgical Procedures		
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
Alveoloplasty - Surgical Preparation of Ridge for Dentures		
7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]
Vestibuloplasty		
7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
Surgical Incision		
7510	Incision and drainage of abscess - intraoral soft tissue.	[50]

[Endodontics]

Pulp Capping		
3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]
Pulpotomy		
3220	Therapeutic pulpotomy (excluding final restoration).	[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)		
3310	One canal (excluding final restoration).	\$ [265]
3320	Two canals (excluding final restoration).	[324]
3330	Three canals (excluding final restoration).	[418]
3340	Four or more canals (excluding final restoration).	[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]
Periapical Services		
3410	Apicoectomy (per tooth) - first root.	[248]

[Periodontics]

Surgical Services (Including Unusual Postoperative Services)		
4210	Gingivectomy or gingivoplasty - per quadrant.	[105]
4211	Gingivectomy or gingivoplasty - per tooth.	[63]
4220	Gingival curettage, by report.	[42]
4240	Gingival flap curettage (including root planning).	[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]
Adjunctive Periodontal Services		
4340	Root Planning - entire mouth.	[296]
4341	Root Planning - per quadrant.	[74]
4910	Periodontal Prophylaxis.	[42]

Adjunctive General Services

Unclassified Treatment		
9110	Palliative (emergency) treatment of dental pain - minor procedures.	[32]

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510	Inlay, metallic - one surface (excluding gold).	[147]
2520	Inlay, metallic - two surfaces (excluding gold).	[171]
2530	Inlay, metallic - three surfaces (excluding gold).	[204]

Crowns - Single Restorations Only

2710	Crown - Plastic (acrylic).	[50]
2721	Crown - resin with predominantly base metal.	[95]
2740	Crown - porcelain/ceramic substrate.	[250]
2752	Crown - porcelain fused with noble metal.	[224]
2810	Crown - 3/4 cast metallic.	[250]
2830	Crown - Stainless steel.	[275]

[Oral Surgery]

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]

Vestibuloplasty

7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
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Surgical Incision

7510	Incision and drainage of abscess - intraoral soft tissue.	[50]]
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[Endodontics]

Pulp Capping

3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]

Pulpotomy		
3220	Therapeutic pulpotomy (excluding final restoration).	[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)		
3310	One canal (excluding final restoration).	\$ [265]
3320	Two canals (excluding final restoration).	[324]
3330	Three canals (excluding final restoration).	[418]
3340	Four or more canals (excluding final restoration).	[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]
Periapical Services		
3410	Apicoectomy (per tooth) - first root.	[248]]
[Periodontics]		
Surgical Services (Including Unusual Postoperative Services)		
4210	Gingivectomy or gingivoplasty - per quadrant.	[105]
4211	Gingivectomy or gingivoplasty - per tooth.	[63]
4220	Gingival curettage, by report.	[42]
4240	Gingival flap curettage (including root planning).	[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]
Adjunctive Periodontal Services		
4340	Root Planning - entire mouth.	[296]
4341	Root Planning - per quadrant.	[74]
4910	Periodontal Prophylaxis.	[42]]
Prosthodontics (Removable)		
Complete Dentures (Including Routine Post Delivery Care)		
5110	Complete upper.	[261]
5120	Complete lower.	[259]
5130	Immediate upper.	[289]
5140	Immediate lower.	[277]
Partial Dentures (Including Routine Post Delivery Care)		
5211	Upper partial - acrylic base (including any conventional clasps and rests).	[313]
5212	Lower partial - acrylic base (including any conventional clasps and rests).	[315]
5213	Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).	[236]
5214	Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).	[236]
5216	Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).	[315]
5281	Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).	[126]
Adjustments to Dentures		

5410	Adjust complete denture - upper (more than six months after installation).		[15]
5411	Adjust complete denture - lower (more than six months after installation).	\$	[16]
5421	Adjust partial denture - upper (more than six months after installation).		[14]
5422	Adjust partial denture - lower (more than six months after installation).		[15]

Repairs to Dentures

5520	Replace missing or broken teeth - complete denture (each tooth)		[42]
5640	Replace broken teeth or denture, no other repairs.		[46]
5650	Add tooth to existing partial denture.		[67]
5660	Add clasp to existing partial denture.		[75]

Denture Reline Procedures

5730	Reline complete upper denture (chair side).		[58]
5731	Reline complete lower denture (chair side).		[66]
5740	Reline upper partial denture (chair side).		[63]
5741	Reline lower partial denture (chair side).		[63]
5750	Reline complete upper denture (laboratory).		[81]
5751	Reline complete lower denture (laboratory).		[82]
5760	Reline upper partial denture (laboratory).		[84]
5761	Reline lower partial denture (laboratory).		[79]

Other Removable Prosthetic Services

5820	Temporary partial - stayplate denture (upper).		[193]
5821	Temporary partial - stayplate denture (lower).		[205]

Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)

Bridge Pontics

6211	Pontic - cast predominantly base metal.		[197]
6241	Pontic - porcelain fused to predominantly base metal.		[210]
6251	Pontic - resin with predominantly base metal.		[213]

Bridge Retainers - Crowns

6710	Crown - resin.		[160]
6721	Crown - resin with predominantly base metal.		[171]
6751	Crown - porcelain fused to predominantly base metal.		[210]
6791	Crown - full cast predominantly base metal.		[208]

Other Fixed Prosthetic Services

6930	Recement bridge.		[42]
6940	Stress breaker.		[101]

Orthodontics (No Scheduled Maximums)

Minor treatment for tooth guidance

8110	Upper retainer.		
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8112 Lower retainer.
8120 Fixed appliance therapy.

Minor treatment to control harmful habits

8210 Removable appliance therapy.
8220 Fixed appliance therapy.

Interceptive orthodontic treatment

8360 Removable appliance therapy.
8370 Fixed appliance therapy.

Comprehensive orthodontic treatment-transitional dentition

8460 Class I malocclusion.
8470 Class II malocclusion.
8480 Class III malocclusion.

Comprehensive orthodontic treatment-permanent dentition

8560 Class I malocclusion.
8570 Class II malocclusion.
8580 Class III malocclusion.

Other orthodontic procedures

8650 Treatment of the atypical or extended skeletal case.
8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

9220 General anesthesia. \$ [116]

Monitor Life Insurance Company of New York

Dental Care Plan

[Doe & Doe, Ltd.]

Group Number: [25-1371]

Effective Date: [January 1, 2011]

Monitor Life Insurance Company of New York

70 Genesee Street
Utica, New York 13502
Telephone 800-422-6200

(Herein called the Company)

Certificate of Insurance of Your Group Dental Program

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Monitor Life Insurance Company of New York** ("Monitor") and cannot modify the Contract in any way.

President
Monitor Life Insurance Company of New York

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Monitor Life Insurance Company of New York

Group Highlights

Applicant Name: [Doe & Doe, Ltd.]

Address: [P. O. Box 14000]
[Utica, New York 13502]

Group Number: [25-1271]

Effective Date: [January 1, 2011]

Contract Term: [January 1, 2011 through December 31, 2011]

Minimum Number of Hours: [Not Applicable]

Eligibility Period: [Not Applicable]

Effective Day of Month: [First day of the month following completion of eligibility]

Open Enrollment Period: [January]

Premiums

Monthly Amount:

For each Primary Enrollee: [\$19.87]

For each Primary Enrollee with
One Dependent Enrollee [\$39.71]

For each Primary Enrollee with more than
One Dependent Enrollee [\$59.73]

Payment Breakdown:

Primary Enrollee shall pay [100%] of Premiums for personal coverage. Primary Enrollee shall pay [100%] of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits:

	Policy Year		
	1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	[80%]	[90%]	[100%]
Type II Procedures (Basic Benefits)			
Preventative	[60%]	[70%]	[80%]
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Restorative	[60%]	[70%]	[80%]
Palliative	[60%]	[70%]	[80%]
Type III Procedures			
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Prosthodontics (Removable & Fixed)	[0%]	[40%]	[50%]
Orthodontics	[0%]	[40%]	[50%]

These percentages are based on the Contract Allowance.

Note - Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

Waiting Periods:

Type I Procedures	[0 months]
Type II Procedures	[0 months]
Type III Procedures	[12 months]

Orthodontic Benefits are limited to Dependent Enrollee children six (6) years to age 19.

Deductible Amount

For each Enrollee	[\$100.00 for the term of each Enrollee's policy per [Contract Year]]
-------------------	--

Any deductible for Orthodontic Benefits an Enrollee satisfied under the Applicant's prior plan will be credited toward the deductible under this plan.

Maximum Amount:

- [\$600.00] per Enrollee per [Contract Year] for Prosthodontic Benefits.
- [\$350.00] per Enrollee per [Contract Year] for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per Lifetime for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per [Contract Year] for All Benefits (Type I, II, & III Combined)
- [\$500.00] per Enrollee age 65 or older per [Calendar Year] for Prosthetics or the repair thereof.]

Monitor will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination:

Less than [Ten (10)] Primary Enrollee(s).

State of Issue: [New York]

Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

- 1.01 **“Applicant”** – the employer, association or other organization or group contracting to obtain Benefits.
- 1.02 **“Approved Amount”** – the total fee chargeable for a Single Procedure.
- 1.03 **“Attending Dentist’s Statement”** – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.
- 1.04 **“Benefits”** – the amounts that Monitor will pay for dental services under Article 4.
- 1.05 **“Calendar Year”** – the 12 months of the year from January 1 through December 31.
- 1.06 **“Contract”** – this agreement between Monitor and Applicant, including the Application and the attachments listed in Article 9.
- 1.07 **“Contract Allowance”** – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist’s submitted fee, and the Scheduled Maximum, if any, and the Dentist’s fee filed with Monitor in the Participating Dentist Agreement, if any, or the UCR.
- 1.08 **“Contract Term”** – the period during which the Contract is in effect, as shown in the Group Highlights page.
- 1.09 **“Contract Year”** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and maximums will be determined using this 12 month period rather than on a calendar year basis.
- 1.10 **“Dentist”** – a person licensed to practice dentistry when and where services are performed.
- 1.11 **“Dependent Enrollee”** – an Eligible Dependent enrolled in the plan to receive Benefits.
- 1.12 **“Effective Date”** – the date the program starts, as shown in the Group Highlights page.
- 1.13 **“Eligible Dependent”** – a dependent of an Eligible Person eligible for Benefits under Article 2.
- 1.14 **“Eligible Person”** – a person as listed in The Group Highlights page, designated by the Applicant as eligible for Benefits under Article 2.
- 1.15 **“Enrollee”** – an Eligible Person (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.
- 1.16 **“Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist”** – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. A Non-Participating Dentist may charge more

than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.

- 1.17 **“Open Enrollment Period”** – the month(s) of the year, as shown in the Group Highlights page, during which Eligible Persons may change coverage for the next [Contract year].
- 1.18 **“Predetermination”** – Monitor shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.
- 1.19 **“Preferred, Network, Contracting, Participating Dentist”** – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. See Non-Participating Dentist.
- 1.20 **“Premiums”** – the amounts payable monthly by the Applicant as required in the Contract.
- 1.21 **“Primary Enrollee”** – an Eligible Person enrolled in the plan to receive Benefits.
- 1.22 **“Procedure Number”** – the number given to a Single Procedure in the Monitor Dental Uniform Procedure Code and Nomenclature attached as Appendix A.
- 1.23 **“Qualifying Family Status Change”** – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.
- 1.24 **“Scheduled Maximum”** – the maximum Contract Allowance for each dental procedure, as shown in Appendix A, if any.
- 1.25 **“Single Procedure”** – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).
- 1.26 **“UCR”** – “usual, customary and reasonable” which have the following meanings:

Usual – A “usual” fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is “customary” when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic areas determined by Monitor to be relevant. Customary fees may be determined on the basis of fees filed with Monitor by Participating Dentist. A Customary fee for a Participating Dentist is that fee which is approved by Monitor in the terms of the Participating Dentist Agreement.

Reasonable – A fee is “reasonable” if it is “usual” and “customary” or if it falls above “usual” and “customary” or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

- 1.27 **“Uniform Procedure Code”** – the Monitor Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.
- 1.28 **“We, Our, or Us”** – Monitor, and will be used without respect to capitalization.
- 1.29 **“You, Your, Yours”** – the Primary Enrollee and will be used without respect to capitalization.

Choice of Dentist

Monitor offers you a choice of selecting a Dentist from our panel of Participating Dentists, if applicable, or you may choose a Non-participating Dentist.

A directory of Participating Dentists is available from your employer. You are responsible for verifying whether the Dentist you select is a Participating Dentist. Dentists are regularly added to the panel so a Participating Dentist may not yet be listed. Additionally, you should always confirm that a listed Dentist is still a Participating Dentist.

You may choose to go to any Dentist. Even if you choose a Participating Dentist from our panel, Monitor cannot guarantee that a particular Dentist will be available.

There may be a difference in the out-of-pocket cost you pay if your Dentist is not a Participating Dentist. A Participating Dentist has contractually agreed not to charge you any amount for services above the Contract Allowance. We pay your Benefits based on the Contract Allowance less any deductibles or maximums that may apply.

If a Dentist is not a Participating Dentist, the amount charged to you may be above that charged by our Participating Dentists. When we pay Benefits for services provided by Non-participating Dentists, we will allow the Contract Allowance, or the fee paid to Participating Dentists. You will then be responsible for any extra amount charged by this Dentist over what Benefits we will pay in addition to any deductibles and maximums specified by the plan. This is called balance billing, that is, the Dentist may bill you for the balance after Monitor’s payment is made.

Who Is Eligible?

Eligibility for Enrollment

All present, permanent members of the association are eligible on the Effective Date.

All future, permanent members of the association shall become eligible on the calendar day of the month shown on the Group Highlights page after they have obtained membership.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Dependents are your:

- a) Lawful spouse;
- b) Unmarried dependent children from birth to their 19th birthday, or 25th birthday, if a full-time student in an accredited school.

“Children” includes natural children, stepchildren, adopted children and foster children. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the moment of placement in the physical custody of the Eligible Person, as certified by the agency making the placement. A child shall automatically be covered for 31 days after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

An unmarried child 19 years or older may continue to be eligible as a dependent if the child is:

- a) Not self-supporting because of mental incapacity or physical handicap that began before age 19; and
- b) The child must be mostly dependent on the Eligible Person for support and maintenance.

Proof of these facts must be given to Monitor or your association if it is requested. Proof will not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

Enrollment Requirements

If you are paying all or a portion of premiums for yourself or your dependents then:

- a) You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.
- b) All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period.
- c) If you elect dependent coverage, you must enroll all of your Eligible Dependents for coverage.
- d) You pay Premiums for Dependent Enrollees in the manner elected by your association and approved by Monitor until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be dropped or changed at any time other than during an Open Enrollment Period or if there is a Qualifying Family Status Change.
- e) If both you and your spouse are Eligible Persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.

Coverage for newborn infants shall be for 90 days.

Coverage for adopted children shall include coverage for any minor under the charge, care, and control of the Insured whom the Insured has filed a petition to adopt. The coverage shall begin on the date of the filing of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, such coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage required by this provision shall terminate upon the dismissal or denial of a petition for adoption.

Loss of Eligibility

Your coverage ends on the last day of the month your membership in the association terminates, or immediately when this program ends. Your dependents' coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this certificate.

Continuation of Benefits

Monitor does not pay Benefits for services received after your coverage ends. But Monitor will pay for Single Procedures started before that date.

[Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family Medical Leave Act of 1993*. If you return to work within six (6) months you will become eligible on the first day of the month following your return. If you are gone more than six (6) months, you will have to re-qualify for coverage just like a new employee. No matter when you return, any deductibles and maximums will start over, just like a new employee.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family Leave Act of 1993. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred. **Important:** The Family Medical Leave Act does **not** apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.]

[Optional Continuation of Coverage (COBRA)

When the Eligible Persons of the employer are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the premium payments, Monitor agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this section.

- a) Right to Continue. Coverage may continue in accordance with the following provisions when:
- (1) You or your Dependent Enrollee becomes ineligible for coverage under the Contract due to a Qualifying Event shown below; and
 - (2) The Contract remains in force.

"Qualifying Event" means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of coverage under this Contract:

- (1) Your termination of employment.
- (2) Your death.

- (3) Divorce or legal separation from you.
- (4) You becoming entitled to Medicare benefits.
- (5) A dependent child ceasing to meet the description of a dependent child.
- (6) A bankruptcy proceeding under Title 11, United States Code with respect to the employer, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee (who retired on or before the date of substantial elimination of coverage), or of a Dependent Enrollee of a retired Primary Enrollee.

“Qualified Beneficiary” means you and any of your Dependent Enrollees who are entitled to continue coverage under the Contract, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) Is acquired during your 18 or 29 month continuation period; and
- (2) Is enrolled for coverage in accordance with the terms of the Contract.

But it does not include your new spouse, stepchild or foster child acquired during the continuation period: whether or not the new Dependent is enrolled for coverage.

b) Continuation Periods. The maximum period of continued coverage for each Qualifying Event shall be as follows:

- (1) Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and any of your Dependent Enrollees may be continued for up to 18 months from the date employment ended. Termination of employment includes a reduction in hours or retirement.

Exceptions:

- (i) Misconduct. If your termination of employment is for gross misconduct, coverage may not be continued for you or any of your Dependent Enrollees.
- (ii) Disability. “Disability” or “Disabled” as used in this section shall be defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If you:

- (a) Become disabled by the 60th day after your employment ends; and
- (b) Are covered for Social Security Disability Income benefits; then coverage for you and any of your Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

If your Dependent Enrollee:

- (a) Becomes disabled by the 60th day after your employment ends; and

- (b) Is covered for Social Security Disability Income benefits; then coverage for that Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

You must send the employer a copy of the Social Security Administration's letter:

- (a) Within 60 days after they find that you or your Dependent Enrollee is disabled, and before the 18 month continuation period expires; and again
- (b) Within 30 days after they find that he or she is no longer disabled.

(iii) Subsequent Qualifying Event. If your Dependent:

- (a) Is a Qualified Beneficiary; and
- (b) Has a subsequent Qualifying Event during the 18 or 29 month continuation period; then coverage for that Dependent Enrollee may be continued for up to 36 months, from the date your employment ended.

(2) Loss of Dependent Eligibility. If a Dependent Enrollee's eligibility ends, due to a Qualifying Event other than your termination of employment; then that Dependent Enrollee's coverage may be continued for up to 36 months, from the date of the event. Such events may include:

- (i) Your death, divorce, legal separation, or Medicare entitlement; and
- (ii) A child reaching the age limit, getting married or ceasing to be a full-time student.

You must notify the employer within 60 days of divorce, a legal separation, or a child ceasing to be an eligible Dependent (as defined by the Contract). One or more subsequent Qualifying Events may occur during the Dependent Enrollee's 36 month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first event.

(3) Medicare Entitlement. If your eligibility under the Contract ends when you become entitled to Medicare benefits; then coverage may not be continued for yourself. But coverage may be continued for any of your Dependent Enrollees for up to 36 months, from your Medicare entitlement date.

If your eligibility under the Contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement; then any of your Dependent Enrollees may continue coverage for up to:

- (i) 36 months from your Medicare entitlement date; or
- (ii) 18 months from the date your employment ended (whichever is later).

c) Election. To continue coverage, you must notify the employer of such election within 60 days from the later of:

- (1) The date of the Qualifying Event;
- (2) The date of the loss of coverage; or
- (3) The date the employer sends notice of the right to continue.

Continued coverage elected under this section shall be effective the first day of the month following the applicable Qualifying Event. However, Benefits shall not be available to a person electing continuation until Monitor receives the data about such person required in the Contract, along with all Premiums then currently payable for such person. Monitor shall not, in any event, make benefits available under this section with respect to any person for whom such information and Premium are not received by Monitor within 60 days after the date such person is required to notify the employer of his or her election as stated above.

d) Termination. Continued coverage will end at the earliest of the following dates:

- (1) The end of the maximum period for continued coverage shown above;
- (2) The date the Contract terminates;
- (3) The last day of the period for which Premium has been paid; if any Premium is not paid when due;
- (4) The date you or your Dependent Enrollee:
 - (i) Becomes covered under any other group dental plan; or
 - (ii) Become eligible for benefits for Medicare.

Once continued coverage ends; it cannot be reinstated.]

Deductible

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible.

Maximum Amount

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

Monitor will receive credit for any amounts paid for Orthodontic Benefits. Those amounts shall be deducted from the maximum paid by Monitor.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with your association is cancelled.

Premiums

You will be responsible for [100%] of the cost of premiums for yourself. You will be responsible for [100%] of the cost of premiums for your Dependent Enrollees.

Monitor may cancel this Program 30 days after written notice to you if monthly Premiums are not paid when due.

Benefits, Limitations & Exclusions

Subject to the limitations and exclusions in this Contract, Monitor shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. Monitor may use dental consultants to determine generally accepted dental practice standards. Eligibility periods, if any, for specific services are shown in Group Highlights.

Patient Copayment - Monitor's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Group Highlights. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Monitor shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.

Limitations on All Benefits – Optional Services. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

No change in Benefits will become effective during a Contract Term unless Applicant and Monitor agree in writing.

Exclusions - Monitor does not pay Benefits for:

- a) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).
- c) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.
- d) Any Single Procedure started before the patient is covered under this program.

- e) Prescribed drugs, medication or painkillers.
- f) Experimental procedures.
- g) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) Services for any disturbance of the temporomandibular joints (jaw joints).
- k) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- l) For services provided outside the United States, its territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.
- m) The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under this dental plan.

Diagnostic and Preventive Benefits (Type I Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal scaling in the presence of inflamed gums is considered to be a Basic Service for payment provisions); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in teeth for the purpose of preventing decay).

Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

- a) Monitor will not pay for more than one (1) cleaning, including periodontal cleanings, done in any six (6) month period that the Enrollee is covered by any Monitor program.
- b) Monitor will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any Monitor program.
- c) Full-mouth x-rays or panographic x-rays will be provided when required by the Dentist, but no more than one set each 36 month period will be paid by Monitor.
- d) Bitewing x-rays are limited to one set each 12 months period.

- e) Topical applications of fluoride are limited to one (1) each twelve month period when provided to Enrollees under age 19; furthermore, Monitor will not pay for topical application of fluoride for an Enrollee 19 years of older.
- f) Sealant applications to any one posterior permanent tooth are limited to one (1) each 36 month period.

4.08 **Basic Benefits (Type II Procedures)** Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Preventative:	space maintainers.
[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Restorative:	Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services.
Palliative:	treatment to relieve pain.

Limitations on Basic Benefits (Type II Procedures) - Monitor will not pay for space maintainers for baby teeth for an Enrollee 16 years or older.

4.10 **Major Benefits (Type III Procedures)** Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Prosthodontics:	Complete & partial dentures (including routine post delivery care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.
Orthodontics:	The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

Limitations on Prosthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] is shown in Group Highlights.
- b) Monitor will not pay to replace any crown, jacket or cast restoration, which the patient received in the previous 5 years.
- c) Monitor will not pay to replace any bridge or denture that the patient received in the previous 5 years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
- d) Monitor limits Benefits for dentures to a standard partial or complete denture. A “standard” denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- e) Monitor will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Monitor will credit the cost of a standard complete or partial denture that would have been allowed under this plan toward the cost of an implant and related services (copayments apply.)

Limitations on Orthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] and Enrollee’s lifetime is shown in Group Highlights.
- b) Payment of Orthodontics is provided monthly.
- c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.
- e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.
- f) X-rays or extractions are not subject to the Orthodontic maximum.
- g) Surgical procedures are not subject to the Orthodontic maximum.
- h) Orthodontic Benefits are limited to Dependent Enrollees within the ages shown in Group Highlights.
- i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for [12] consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant’s previous plan.

Coordination of Benefits

Monitor matches the Benefits under this program with your benefits under any other group pre-paid program or benefit plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's fees for covered services. If this is the "primary" program, Monitor shall not reduce Benefits. But if the other program is the primary one, Monitor shall reduce Benefits otherwise payable under this program. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under this program (see BENEFITS, LIMITATIONS & EXCLUSIONS).

How does Monitor determine which is the "primary" program?:

- a) If the other program is not primarily a dental program, this program is primary.
- b) If the other program is a dental program, the following rules are applied:
 - (1) The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
 - (2) The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.
- c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Claims

Claims for Benefits must be filed on a standard Attending Dentist Statement that you or your Dentist may obtain from:

Monitor Life Insurance Company of New York
Attn: Membership Services
P.O. Box 16708
Jackson, Mississippi 39236
(800) 800-1397

Claims not paid within 45 days of due written proof of loss are subject to a charge of 1 and ½ percent interest per month.

Predeterminations

A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. Monitor will predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term or beyond the date of the patient's coverage ends.

Claims Appeal

Monitor will notify the Enrollee if any services submitted on a claim are denied coverage as Benefits, in whole or in part, stating the reason or reasons for the denial. Within 60 days after the receipt of a notice of denial the Enrollee may make a written request for a review of the denial by addressing a letter to Monitor stating the reason(s) for review or reconsideration and providing any pertinent documents which the Enrollee wishes Monitor to review.

Monitor will make a full and fair review. Monitor may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of your local dental society. A decision will be sent to the Primary Enrollee within 30 days after your request for an appeal is received, unless it is referred to a peer review committee or other unusual circumstances arise. In no event will the decision take longer than 120 days.

Cancellation of Program

Monitor may cancel the program only:

- a) On an anniversary of the Effective Date; or
- b) If your association does not pay the monthly premiums; or
- c) If your association does not provide a list of who is eligible; or
- d) If less than the minimum number of Primary Enrollees required under the Contract reported eligible for three months or more.

Proof of Loss

Before approving a claim, Monitor will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Monitor, in or near his community or residence. Monitor shall in every case hold such information and records confidential.

Monitor will give any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Monitor. If the form is not furnished by Monitor within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Monitor, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Affirmative proof of loss must be furnished to Monitor at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of loss within that time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss and that such proof of loss was furnished as soon as was reasonably possible.

Time of Payment

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Subject to due written proof of loss, all accrued indemnities for loss which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

The Company shall pay or deny a clean claim within 30 days after receipt by the Company if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.

Payments will be made within 45 days (30 days if filed electronically) if any claim is not denied for valid and proper reasons within 45 days (30 days if filed electronically) after receipt of due written proof. The Company pays interest at the rate of 1 and ½ percent per month on the amount of the claim until it is finally settled or adjudicated. If the Company does not pay a claim when due, the insured may bring action to recover benefits and any other damages.

To Whom Benefits are Paid

Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him.

Legal Actions

No action at law or in equity shall be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor shall an action be brought at all unless brought within 3 years from expiration of the time within proof of loss is required by the Contract.

This Certificate of Insurance constitutes only a summary of the dental service insurance Contract. The complete Contract must be consulted to determine the exact terms and conditions of coverage.

APPENDIX A

MONITOR UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a complete list of the dental procedures for which benefits are payable under this Certificate and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120	Periodic oral examination.	\$	[21]
0130	Emergency oral examination.		[21]

Radiographs

0210	Intraoral - complete series (including bitewings).	[50]
0220	Intraoral periapical - first film.	[10]
0230	Intraoral periapical - each additional film up to 12.	[6]
0240	Intraoral - occlusal film.	[11]
0250	Extraoral - first film.	[10]
0260	Extraoral - each additional film.	[13]
0270	Bitewing - single films.	[12]
0272	Bitewings - two films.	[16]
0274	Bitewings - four films.	[22]
0330	Panographic film.	[44]

Tests and Laboratory Examinations

0470	Diagnostic cast.	[40]
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Preventive

Dental Prophylaxis

1110	Prophylaxis - adult.	[32]
1120	Prophylaxis - child.	[26]

Topical Fluoride Treatment (Office Procedure)

1201	Topical application of fluoride (including prophylaxis) - child.	[38]
1202	Topical application of fluoride (including prophylaxis) - adult.	[44]
1203	Topical application of fluoride (excluding prophylaxis) - child.	[13]
1204	Topical application of fluoride (excluding prophylaxis) - adult.	[13]

Other Preventive Services

1351	Sealant - per tooth.	[16]
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BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510	Space Maintainer - fixed unilateral.	\$	[131]
1515	Space Maintainer - fixed-bilateral.		[231]
1520	Space Maintainer - removable-unilateral.		[170]
1525	Space Maintainer - removable-bilateral.		[200]
1550	Recementation of space maintainer.		[32]

Restorative

Amalgam Restorations (including Polishing)

2110	Amalgam - one surface, primary.		[34]
2120	Amalgam - two surfaces, primary.		[43]
2130	Amalgam - three surfaces, primary.		[54]
2140	Amalgam - one surface, permanent.		[32]
2150	Amalgam - two surfaces, permanent.		[42]
2160	Amalgam - three surfaces, permanent.		[53]

Silicate Restorations

2210	Silicate cement - per restoration.		[21]
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Filled or Unfilled Resin Restorations

2310	Acrylic or plastic.		[30]
2330	Resin - one surface.		[37]
2331	Resin - two surface.		[47]
2332	Resin - three surfaces.		[58]

Other Restorative Services.

2940	Sedative filling.		[34]
2950	Crown buildup - pin retained.		[84]
2951	Pin retention - per tooth, in addition to restoration.		[19]
2953	Cast post as part of crown.		[144]
2954	Prefabricated post and core in addition to crown.		[125]
2970	Temporary (fractured tooth).		[84]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.		[38]
7120	Each additional tooth.		[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal lap and removal of bone and/or section of tooth.	[76]	
7220	Removal of impacted tooth - soft tissue.		[109]
7230	Removal of impacted tooth - partially bony.		[153]
7240	Removal of impacted tooth - completely bony.		[\$184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).		[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures			
7310	Alveoloplasty in conjunction with extractions - per quadrant.		[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.		[96]
Vestibuloplasty			
7340	Vestibuloplasty - ridge extension (secondary epithelialization).		[151]
Surgical Incision			
7510	Incision and drainage of abscess - intraoral soft tissue.		[50]]
[Endodontics			
Pulp Capping			
3110	Pulp cap - direct (excluding final restoration).		[26]
3120	Pulp cap - indirect (excluding final restoration).		[21]
Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration).		[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)			
3310	One canal (excluding final restoration).	\$	[265]
3320	Two canals (excluding final restoration).		[324]
3330	Three canals (excluding final restoration).		[418]
3340	Four or more canals (excluding final restoration).		[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).		[150]
Periapical Services			
3410	Apicoectomy (per tooth) - first root.		[248]]
[Periodontics			
Surgical Services (Including Unusual Postoperative Services)			
4210	Gingivectomy or gingivoplasty - per quadrant.		[105]
4211	Gingivectomy or gingivoplasty - per tooth.		[63]
4220	Gingival curettage, by report.		[42]
4240	Gingival flap curettage (including root planning).		[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.		[315]
Adjunctive Periodontal Services			
4340	Root Planning - entire mouth.		[296]
4341	Root Planning - per quadrant.		[74]
4910	Periodontal Prophylaxis.		[42]]
Adjunctive General Services			
Unclassified Treatment			
9110	Palliative (emergency) treatment of dental pain - minor procedures.		[32]

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510	Inlay, metallic - one surface (excluding gold).	[147]
2520	Inlay, metallic - two surfaces (excluding gold).	[171]
2530	Inlay, metallic - three surfaces (excluding gold).	[204]

Crowns - Single Restorations Only

2710	Crown - Plastic (acrylic).	[50]
2721	Crown - resin with predominantly base metal.	[95]
2740	Crown - porcelain/ceramic substrate. [250]	
2752	Crown - porcelain fused with noble metal.	[224]
2810	Crown - 3/4 cast metallic.	[250]
2830	Crown - Stainless steel.	[275]

[Oral Surgery]

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]

Vestibuloplasty

7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
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Surgical Incision

7510	Incision and drainage of abscess - intraoral soft tissue.	[50]]
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[Endodontics]

Pulp Capping

3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]

Pulpotomy

3220	Therapeutic pulpotomy (excluding final restoration).	[63]
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Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)

3310	One canal (excluding final restoration).	\$[265]
3320	Two canals (excluding final restoration).	[324]
3330	Three canals (excluding final restoration).	[418]
3340	Four or more canals (excluding final restoration).	[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]

Periapical Services

3410	Apicoectomy (per tooth) - first root.	[248]]
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[Periodontics**Surgical Services (Including Unusual Postoperative Services)**

4210	Gingivectomy or gingivoplasty - per quadrant.	[105]
4211	Gingivectomy or gingivoplasty - per tooth.	[63]
4220	Gingival curettage, by report.	[42]
4240	Gingival flap curettage (including root planning).	[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]

Adjunctive Periodontal Services

4340	Root Planning - entire mouth.	[296]
4341	Root Planning - per quadrant.	[74]
4910	Periodontal Prophylaxis.	[42]]

Prosthodontics (Removable)**Complete Dentures (Including Routine Post Delivery Care)**

5110	Complete upper.	[261]
5120	Complete lower.	[259]
5130	Immediate upper.	[289]
5140	Immediate lower.	[277]

Partial Dentures (Including Routine Post Delivery Care)

5211	Upper partial - acrylic base (including any conventional clasps and rests).	[313]
5212	Lower partial - acrylic base (including any conventional clasps and rests).	[315]
5213	Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).	[236]
5214	Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).	[236]
5216	Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).	[315]
5281	Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).	[126]

Adjustments to Dentures

5410	Adjust complete denture - upper (more than six months after installation).	[15]
5411	Adjust complete denture - lower (more than six months after installation).	\$ [16]
5421	Adjust partial denture - upper (more than six months after installation).	[14]
5422	Adjust partial denture - lower (more than six months after installation).	[15]

Repairs to Dentures

5520	Replace missing or broken teeth - complete denture (each tooth)	[42]
5640	Replace broken teeth or denture, no other repairs.	[46]
5650	Add tooth to existing partial denture.	[67]
5660	Add clasp to existing partial denture.	[75]

Denture Reline Procedures

5730	Reline complete upper denture (chair side).	[58]
5731	Reline complete lower denture (chair side).	[66]
5740	Reline upper partial denture (chair side).	[63]
5741	Reline lower partial denture (chair side).	[63]
5750	Reline complete upper denture (laboratory).	[81]
5751	Reline complete lower denture (laboratory).	[82]
5760	Reline upper partial denture (laboratory).	[84]
5761	Reline lower partial denture (laboratory).	[79]

Other Removable Prosthetic Services

5820	Temporary partial - stayplate denture (upper).	[193]
5821	Temporary partial - stayplate denture (lower).	[205]

Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)**Bridge Pontics**

6211	Pontic - cast predominantly base metal.	[197]
6241	Pontic - porcelain fused to predominantly base metal.	[210]
6251	Pontic - resin with predominantly base metal.	[213]

Bridge Retainers - Crowns

6710	Crown - resin.	[160]
6721	Crown - resin with predominantly base metal.	[171]
6751	Crown - porcelain fused to predominantly base metal.	[210]
6791	Crown - full cast predominantly base metal.	[208]

Other Fixed Prosthetic Services

6930	Recement bridge.	[42]
6940	Stress breaker.	[101]

Orthodontics (No Scheduled Maximums)**Minor treatment for tooth guidance**

8110	Upper retainer.
8112	Lower retainer.
8120	Fixed appliance therapy.

Minor treatment to control harmful habits

8210	Removable appliance therapy.
8220	Fixed appliance therapy.

Interceptive orthodontic treatment

8360	Removable appliance therapy.
8370	Fixed appliance therapy.

Comprehensive orthodontic treatment-transitional dentition

- 8460 Class I malocclusion.
- 8470 Class II malocclusion.
- 8480 Class III malocclusion.

Comprehensive orthodontic treatment-permanent dentition

- 8560 Class I malocclusion.
- 8570 Class II malocclusion.
- 8580 Class III malocclusion.

Other orthodontic procedures

- 8650 Treatment of the atypical or extended skeletal case.
- 8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

- 9220 General anesthesia. \$ [116]

Monitor Life Insurance Company of New York

Dental Care Plan

[Doe & Doe, Ltd.]

Group Number: [25-1371]

Effective Date: [January 1, 2011]

Monitor Life Insurance Company of New York

70 Genesee Street
Utica, New York 13502
Telephone 800-422-6200

(Herein called the Company)

Certificate of Insurance of Your Group Dental Program

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Monitor Life Insurance Company of New York** ("Monitor") and cannot modify the Contract in any way.

President
Monitor Life Insurance Company of New York

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Monitor Life Insurance Company of New York

Group Highlights

Applicant Name: [Doe & Doe, Ltd.]

Address: [P. O. Box 14000]
[Utica, New York 13502]

Group Number: [25-1271]

Effective Date: [January 1, 2011]

Contract Term: [January 1, 2011 through December 31, 2011]

Minimum Number of Hours: [20 hours per week]

Eligibility Period: [Three (3) months]

Effective Day of Month: [First day of the month following completion of eligibility]

Open Enrollment Period: [January]

Premiums

Monthly Amount:

For each Primary Enrollee: [\$19.87]

For each Primary Enrollee with
One Dependent Enrollee [\$39.71]

For each Primary Enrollee with more than
One Dependent Enrollee [\$59.73]

Payment Breakdown:

Primary Enrollee shall pay [100%] of Premiums for personal coverage. Primary Enrollee shall pay [100%] of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits:

	Policy Year		
	1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	[80%]	[90%]	[100%]
Type II Procedures (Basic Benefits)			
Preventative	[60%]	[70%]	[80%]
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Restorative	[60%]	[70%]	[80%]
Palliative	[60%]	[70%]	[80%]
Type III Procedures			
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Prosthodontics (Removable & Fixed)	[0%]	[40%]	[50%]
Orthodontics	[0%]	[40%]	[50%]

These percentages are based on the Contract Allowance.

Note - Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

Waiting Periods:

Type I Procedures	[0 months]
Type II Procedures	[0 months]
Type III Procedures	[12 months]

Orthodontic Benefits are limited to Dependent Enrollee children six (6) years to age 19.

Deductible Amount

For each Enrollee	[\$100.00 for the term of each Enrollee's policy per [Contract Year]]
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Any deductible for Orthodontic Benefits an Enrollee satisfied under the Applicant's prior plan will be credited toward the deductible under this plan.

Maximum Amount:

[\$600.00] per Enrollee per [Contract Year] for Prosthodontic Benefits.
[\$350.00] per Enrollee per [Contract Year] for Orthodontic Benefits.
[\$1,000.00] per Enrollee per Lifetime for Orthodontic Benefits.
[\$1,000.00] per Enrollee per [Contract Year] for All Benefits (Type I, II, & III Combined)
[\$500.00] per Enrollee age 65 or older per [Calendar Year] for Prosthetics or the repair thereof.]

Monitor will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination:

Less than [Ten (10)] Primary Enrollee(s).

State of Issue: [New York]

Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

- 1.01 **“Applicant”** – the employer, association or other organization or group contracting to obtain Benefits.
- 1.02 **“Approved Amount”** – the total fee chargeable for a Single Procedure.
- 1.03 **“Attending Dentist’s Statement”** – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.
- 1.04 **“Benefits”** – the amounts that Monitor will pay for dental services under Article 4.
- 1.05 **“Calendar Year”** – the 12 months of the year from January 1 through December 31.
- 1.06 **“Contract”** – this agreement between Monitor and Applicant, including the Application and the attachments listed in Article 9.
- 1.07 **“Contract Allowance”** – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist’s submitted fee, and the Scheduled Maximum, if any, and the Dentist’s fee filed with Monitor in the Participating Dentist Agreement, if any, or the UCR.
- 1.08 **“Contract Term”** – the period during which the Contract is in effect, as shown in the Group Highlights page.
- 1.09 **“Contract Year”** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and maximums will be determined using this 12 month period rather than on a calendar year basis.
- 1.10 **“Dentist”** – a person licensed to practice dentistry when and where services are performed.
- 1.11 **“Dependent Enrollee”** – an Eligible Dependent enrolled in the plan to receive Benefits.
- 1.12 **“Effective Date”** – the date the program starts, as shown in the Group Highlights page.
- 1.13 **“Eligible Dependent”** – a dependent of an Eligible Person eligible for Benefits under Article 2.
- 1.14 **“Eligible Person”** – a person as listed in the Group Highlights page, designated by the Applicant as eligible for Benefits under Article 2.
- 1.15 **“Enrollee”** – an Eligible Person (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.
- 1.16 **“Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist”** – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor

contracts to assist it in administering the Benefits described in this Contract. A Non-Participating Dentist may charge more than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.

- 1.17 **“Open Enrollment Period”** – the month(s) of the year, as shown in the Group Highlights page, during which Eligible Persons may change coverage for the next [Contract year].
- 1.18 **“Predetermination”** – Monitor shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.
- 1.19 **“Preferred, Network, Contracting, Participating Dentist”** – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. See Non-Participating Dentist.
- 1.20 **“Premiums”** – the amounts payable monthly by the Applicant as required in the Contract.
- 1.21 **“Primary Enrollee”** – an Eligible Person enrolled in the plan to receive Benefits.
- 1.22 **“Procedure Number”** – the number given to a Single Procedure in the Monitor Dental Uniform Procedure Code and Nomenclature attached as Appendix A.
- 1.23 **“Qualifying Family Status Change”** – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.
- 1.24 **“Scheduled Maximum”** – the maximum Contract Allowance for each dental procedure, as shown in Appendix A, if any.
- 1.25 **“Single Procedure”** – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).
- 1.26 **“UCR”** – “usual, customary and reasonable” which have the following meanings:

Usual – A “usual” fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is “customary” when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic areas determined by Monitor to be relevant. Customary fees may be determined on the basis of fees filed with Monitor by Participating Dentist. A Customary fee for a Participating Dentist is that fee which is approved by Monitor in the terms of the Participating Dentist Agreement.

Reasonable – A fee is “reasonable” if it is “usual” and “customary” or if it falls above “usual” and “customary” or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

- 1.27 **“Uniform Procedure Code”** – the Monitor Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.
- 1.28 **“We, Our, or Us”** – Monitor, and will be used without respect to capitalization.
- 1.29 **“You, Your, Yours”** – the Primary Enrollee and will be used without respect to capitalization.

Choice of Dentist

Monitor offers you a choice of selecting a Dentist from our panel of Participating Dentists, if applicable, or you may choose a Non-participating Dentist.

A directory of Participating Dentists is available from your employer. You are responsible for verifying whether the Dentist you select is a Participating Dentist. Dentists are regularly added to the panel so a Participating Dentist may not yet be listed. Additionally, you should always confirm that a listed Dentist is still a Participating Dentist.

You may choose to go to any Dentist. Even if you choose a Participating Dentist from our panel, Monitor cannot guarantee that a particular Dentist will be available.

There may be a difference in the out-of-pocket cost you pay if your Dentist is not a Participating Dentist. A Participating Dentist has contractually agreed not to charge you any amount for services above the Contract Allowance. We pay your Benefits based on the Contract Allowance less any deductibles or maximums that may apply.

If a Dentist is not a Participating Dentist, the amount charged to you may be above that charged by our Participating Dentists. When we pay Benefits for services provided by Non-participating Dentists, we will allow the Contract Allowance, or the fee paid to Participating Dentists. You will then be responsible for any extra amount charged by this Dentist over what Benefits we will pay in addition to any deductibles and maximums specified by the plan. This is called balance billing, that is, the Dentist may bill you for the balance after Monitor’s payment is made.

Who Is Eligible?

Eligibility for Enrollment

All present, permanent employees working the minimum number of hours per week shown on the Group Highlights page are eligible on the Effective Date.

All future, permanent employees shall become eligible on the calendar day of the month shown on the Group Highlights page after they have worked full-time for the minimum number of months of continuous employment shown on the Group Highlights page.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Dependents are your:

- a) Lawful spouse;
- b) Unmarried dependent children from birth to their 19th birthday, or 25th birthday, if a full-time student in an accredited school.

“Children” includes natural children, stepchildren, adopted children and foster children. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the moment of placement in the physical custody of the Eligible Person, as certified by the agency making the placement. A child shall automatically be covered for 31 days after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

An unmarried child 19 years or older may continue to be eligible as a dependent if the child is:

- a) Not self-supporting because of mental incapacity or physical handicap that began before age 19, and
- b) The child must be mostly dependent on the Eligible Person for support and maintenance.

Proof of these facts must be given to Monitor or your employer if it is requested. Proof will not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

Enrollment Requirements

If you are paying all or a portion of premiums for yourself or your dependents then:

- a) You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.
- b) All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period.
- c) If you elect dependent coverage, you must enroll all of your Eligible Dependents for coverage.
- d) You pay Premiums for Dependent Enrollees in the manner elected by your employer and approved by Monitor until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be dropped or changed at any time other than during an Open Enrollment Period or if there is a Qualifying Family Status Change.
- e) If both you and your spouse are Eligible Persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.

Coverage for newborn infants shall be for 90 days.

Coverage for adopted children shall include coverage for any minor under the charge, care, and control of the Insured whom the Insured has filed a petition to adopt. The coverage shall begin on the date of the filing

of a petition for adoption if the Insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, such coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage required by this provision shall terminate upon the dismissal or denial of a petition for adoption.

Loss of Eligibility

Your coverage ends on the last day of the month you stop working for your employer, or immediately when this program ends. Your dependents' coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this certificate.

Continuation of Benefits

Monitor does not pay Benefits for services received after your coverage ends. But Monitor will pay for Single Procedures started before that date.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family Medical Leave Act of 1993*. If you return to work within six (6) months you will become eligible on the first day of the month following your return. If you are gone more than six (6) months, you will have to re-qualify for coverage just like a new employee. No matter when you return, any deductibles and maximums will start over, just like a new employee.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family Leave Act of 1993. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred. **Important:** The Family Medical Leave Act does **not** apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

Optional Continuation of Coverage (COBRA)

When the Eligible Persons of the employer are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the premium payments, Monitor agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this section.

- a) Right to Continue. Coverage may continue in accordance with the following provisions when:
 - (1) You or your Dependent Enrollee becomes ineligible for coverage under the Contract due to a Qualifying Event shown below; and
 - (2) The Contract remains in force.

"Qualifying Event" means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of coverage under this Contract:

- (1) Your termination of employment.

- (2) Your death.
- (3) Divorce or legal separation from you.
- (4) You becoming entitled to Medicare benefits.
- (5) A dependent child ceasing to meet the description of a dependent child.
- (6) A bankruptcy proceeding under Title 11, United States Code with respect to the employer, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee (who retired on or before the date of substantial elimination of coverage), or of a Dependent Enrollee of a retired Primary Enrollee.

“Qualified Beneficiary” means you and any of your Dependent Enrollees who are entitled to continue coverage under the Contract, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) Is acquired during your 18 or 29 month continuation period; and
- (2) Is enrolled for coverage in accordance with the terms of the Contract.

But it does not include your new spouse, stepchild or foster child acquired during the continuation period: whether or not the new Dependent is enrolled for coverage.

b) Continuation Periods. The maximum period of continued coverage for each Qualifying Event shall be as follows:

- (1) Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and any of your Dependent Enrollees may be continued for up to 18 months from the date employment ended. Termination of employment includes a reduction in hours or retirement.

Exceptions:

- (i) Misconduct. If your termination of employment is for gross misconduct, coverage may not be continued for you or any of your Dependent Enrollees.
- (ii) Disability. “Disability” or “Disabled” as used in this section shall be defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If you:

- (a) Become disabled by the 60th day after your employment ends; and
- (b) Are covered for Social Security Disability Income benefits; then coverage for you and any of your Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

If your Dependent Enrollee:

- (a) Becomes disabled by the 60th day after your employment ends; and

- (b) Is covered for Social Security Disability Income benefits; then coverage for that Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

You must send the employer a copy of the Social Security Administration's letter:

- (a) Within 60 days after they find that you or your Dependent Enrollee is disabled, and before the 18 month continuation period expires; and again
- (b) Within 30 days after they find that he or she is no longer disabled.

(iii) Subsequent Qualifying Event. If your Dependent:

- (a) Is a Qualified Beneficiary; and
- (b) Has a subsequent Qualifying Event during the 18 or 29 month continuation period; then coverage for that Dependent Enrollee may be continued for up to 36 months, from the date your employment ended.

(2) Loss of Dependent Eligibility. If a Dependent Enrollee's eligibility ends, due to a Qualifying Event other than your termination of employment; then that Dependent Enrollee's coverage may be continued for up to 36 months, from the date of the event. Such events may include:

- (i) Your death, divorce, legal separation, or Medicare entitlement; and
- (ii) A child reaching the age limit, getting married or ceasing to be a full-time student.

You must notify the employer within 60 days of divorce, a legal separation, or a child ceasing to be an eligible Dependent (as defined by the Contract). One or more subsequent Qualifying Events may occur during the Dependent Enrollee's 36 month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first event.

(3) Medicare Entitlement. If your eligibility under the Contract ends when you become entitled to Medicare benefits; then coverage may not be continued for yourself. But coverage may be continued for any of your Dependent Enrollees for up to thirty-six (36) months, from your Medicare entitlement date.

If your eligibility under the Contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement; then any of your Dependent Enrollees may continue coverage for up to:

- (i) 36 months from your Medicare entitlement date; or
- (ii) 18 months from the date your employment ended (whichever is later).

c) Election. To continue coverage, you must notify the employer of such election within 60 days from the later of:

- (1) The date of the Qualifying Event;
- (2) The date of the loss of coverage; or

- (3) The date the employer sends notice of the right to continue.

Continued coverage elected under this section shall be effective the first day of the month following the applicable Qualifying Event. However, Benefits shall not be available to a person electing continuation until Monitor receives the data about such person required in the Contract, along with all Premiums then currently payable for such person. Monitor shall not, in any event, make benefits available under this section with respect to any person for whom such information and Premium are not received by Monitor within 60 days after the date such person is required to notify the employer of his or her election as stated above.

d) Termination. Continued coverage will end at the earliest of the following dates:

- (1) The end of the maximum period for continued coverage shown above;
- (2) The date the Contract terminates;
- (3) The last day of the period for which Premium has been paid; if any Premium is not paid when due;
- (4) The date you or your Dependent Enrollee:
 - (i) Becomes covered under any other group dental plan; or
 - (ii) Become eligible for benefits for Medicare.

Once continued coverage ends; it cannot be reinstated.

Deductible

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible.

Maximum Amount

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

Monitor will receive credit for any amounts paid for Orthodontic Benefits. Those amounts shall be deducted from the maximum paid by Monitor.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with your employer is cancelled.

Premiums

You will be responsible for [100%] of the cost of premiums for yourself. You will be responsible for [100%] of the cost of premiums for your Dependent Enrollees.

Monitor may cancel this Program 30 days after written notice to your employer if monthly Premiums are not paid when due.

Benefits, Limitations & Exclusions

Subject to the limitations and exclusions in this Contract, Monitor shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. Monitor may use dental consultants to determine generally accepted dental practice standards. Eligibility periods, if any, for specific services are shown in Group Highlights.

Patient Copayment - Monitor's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Group Highlights. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Monitor shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.

Limitations on All Benefits – Optional Services. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

No change in Benefits will become effective during a Contract Term unless Applicant and Monitor agree in writing.

Exclusions - Monitor does not pay Benefits for:

- a) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).

- c) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.
- d) Any Single Procedure started before the patient is covered under this program.
- e) Prescribed drugs, medication or painkillers.
- f) Experimental procedures.
- g) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) Services for any disturbance of the temporomandibular joints (jaw joints).
- k) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- l) For services provided outside the United States, its territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.
- m) The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under this dental plan.

Diagnostic and Preventive Benefits (Type I Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal scaling in the presence of inflamed gums is considered to be a Basic Service for payment provisions); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in teeth for the purpose of preventing decay).

Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

- a) Monitor will not pay for more than one (1) cleaning, including periodontal cleanings, done in any six (6) month period that the Enrollee is covered by any Monitor program.

- b) Monitor will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any Monitor program.
- c) Full-mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but no more than one set each 36-month period will be paid by Monitor.
- d) Bitewing x-rays are limited to one (1) set each twelve (12) months period.
- e) Topical applications of fluoride are limited to one (1) each twelve (12) month period when provided to Enrollees under age 19; furthermore, Monitor will not pay for topical application of fluoride for an Enrollee 19 years of older.
- f) Sealant applications to any one posterior permanent tooth are limited to one (1) each 36-month period.

Basic Benefits (Type II Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Preventative:	space maintainers.
[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Restorative:	Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services
Palliative:	treatment to relieve pain.

Limitations on Basic Benefits (Type II Procedures) - Monitor will not pay for space maintainers for baby teeth for an Enrollee 16 years or older.

Major Benefits (Type III Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Prosthodontics:	Complete & partial dentures (including routine post delivery care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable

prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.

Orthodontics: The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

Limitations on Prosthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] is shown in Group Highlights.
- b) Monitor will not pay to replace any crown, jacket or cast restoration, which the patient received in the previous five (5) years.
- c) Monitor will not pay to replace any bridge or denture that the patient received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
- d) Monitor limits Benefits for dentures to a standard partial or complete denture. A “standard” denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- e) Monitor will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Monitor will credit the cost of a standard complete or partial denture that would have been allowed under this plan toward the cost of an implant and related services (copayments apply.)

Limitations on Orthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] and Enrollee’s lifetime is shown in Group Highlights.
- b) Payment of Orthodontics is provided monthly.
- c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.
- e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.
- f) X-rays or extractions are not subject to the Orthodontic maximum.
- g) Surgical procedures are not subject to the Orthodontic maximum.
- h) Orthodontic Benefits are limited to Dependent Enrollees within the ages shown in Group Highlights.

- i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for [12] consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant's previous plan.

Coordination of Benefits

Monitor matches the Benefits under this program with your benefits under any other group pre-paid program or benefit plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's fees for covered services. If this is the "primary" program, Monitor shall not reduce Benefits. But if the other program is the primary one, Monitor shall reduce Benefits otherwise payable under this program. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under this program (see BENEFITS, LIMITATIONS & EXCLUSIONS).

How does Monitor determine which is the "primary" program?

- a) If the other program is not primarily a dental program, this program is primary.
- b) If the other program is a dental program, the following rules are applied:
 - (1) The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
 - (2) The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.
- c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Claims

Claims for Benefits must be filed on a standard Attending Dentist Statement that you or your Dentist may obtain from:

Monitor Life Insurance Company of New York
Attn: Membership Services
P.O. Box 16708
Jackson, Mississippi 39236
(800) 800-1397

Claims not paid within 45 days of due written proof of loss are subject to a charge of 1 and ½ percent interest per month.

Predeterminations

A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. Monitor will predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term or beyond the date of the patient's coverage ends.

Claims Appeal

Monitor will notify the Enrollee if any services submitted on a claim are denied coverage as Benefits, in whole or in part, stating the reason or reasons for the denial. Within 60 days after the receipt of a notice of denial the Enrollee may make a written request for a review of the denial by addressing a letter to Monitor stating the reason(s) for review or reconsideration and providing any pertinent documents which the Enrollee wishes Monitor to review.

Monitor will make a full and fair review. Monitor may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of your local dental society. A decision will be sent to the Primary Enrollee within 30 days after your request for an appeal is received, unless it is referred to a peer review committee or other unusual circumstances arise. In no event will the decision take longer than 120 days.

Cancellation of Program

Monitor may cancel the program only:

- a) On an anniversary of the Effective Date; or
- b) If your employer does not pay the monthly premiums; or
- c) If your employer does not provide a list of who is eligible; or
- d) If less than the minimum number of Primary Enrollees required under the Contract reported eligible for three months or more.

Proof of Loss

Before approving a claim, Monitor will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Monitor, in or near his community or residence. Monitor shall in every case hold such information and records confidential.

Monitor will give any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Monitor. If the form is not furnished by Monitor within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Monitor, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Affirmative proof of loss must be furnished to Monitor at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of loss within that time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss and that such proof of loss was furnished as soon as was reasonably possible.

Time of Payment

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Subject to due written proof of loss, all accrued indemnities for loss which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

The Company shall pay or deny a clean claim within 30 days after receipt by the Company if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.

Payments will be made within 45 days (30 days if filed electronically) if any claim is not denied for valid and proper reasons within 45 days (30 days if filed electronically) after receipt of due written proof. The Company pays interest at the rate of 1 and ½ percent per month on the amount of the claim until it is finally settled or adjudicated. If the Company does not pay a claim when due, the insured may bring action to recover benefits and any other damages.

To Whom Benefits are Paid

Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him.

Legal Actions

No action at law or in equity shall be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor shall an action be brought at all unless brought within 3 years from expiration of the time within proof of loss is required by the Contract.

This Certificate of Insurance constitutes only a summary of the dental service insurance Contract. The complete Contract must be consulted to determine the exact terms and conditions of coverage.

APPENDIX A

MONITOR UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a Complete list of the dental procedures for which benefits are payable under this Certificate and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120	Periodic oral examination.	\$	[21]
0130	Emergency oral examination.		[21]

Radiographs

0210	Intraoral - complete series (including bitewings).	[50]
0220	Intraoral periapical - first film.	[10]
0230	Intraoral periapical - each additional film up to 12.	[6]
0240	Intraoral - occlusal film.	[11]
0250	Extraoral - first film.	[10]
0260	Extraoral - each additional film.	[13]
0270	Bitewing - single films.	[12]
0272	Bitewings - two films.	[16]
0274	Bitewings - four films.	[22]
0330	Panographic film.	[44]

Tests and Laboratory Examinations

0470	Diagnostic cast.	[40]
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Preventive

Dental Prophylaxis

1110	Prophylaxis - adult.	[32]
1120	Prophylaxis - child.	[26]

Topical Fluoride Treatment (Office Procedure)

1201	Topical application of fluoride (including prophylaxis) - child.	[38]
1202	Topical application of fluoride (including prophylaxis) - adult.	[44]
1203	Topical application of fluoride (excluding prophylaxis) - child.	[13]
1204	Topical application of fluoride (excluding prophylaxis) - adult.	[13]

Other Preventive Services

1351	Sealant - per tooth.	[16]
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BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510	Space Maintainer - fixed unilateral.	\$	[131]
1515	Space Maintainer - fixed-bilateral.		[231]
1520	Space Maintainer - removable-unilateral.		[170]
1525	Space Maintainer - removable-bilateral.		[200]
1550	Recementation of space maintainer.		[32]

Restorative

Amalgam Restorations (including Polishing)

2110	Amalgam - one surface, primary.		[34]
2120	Amalgam - two surfaces, primary.		[43]
2130	Amalgam - three surfaces, primary.		[54]
2140	Amalgam - one surface, permanent.		[32]
2150	Amalgam - two surfaces, permanent.		[42]
2160	Amalgam - three surfaces, permanent.		[53]

Silicate Restorations

2210	Silicate cement - per restoration.		[21]
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Filled or Unfilled Resin Restorations

2310	Acrylic or plastic.		[30]
2330	Resin - one surface.		[37]
2331	Resin - two surface.		[47]
2332	Resin - three surfaces.		[58]

Other Restorative Services.

2940	Sedative filling.		[34]
2950	Crown buildup - pin retained.		[84]
2951	Pin retention - per tooth, in addition to restoration.		[19]
2953	Cast post as part of crown.		[144]
2954	Prefabricated post and core in addition to crown.		[125]
2970	Temporary (fractured tooth).		[84]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.		[38]
7120	Each additional tooth.		[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal lap and removal of bone and/or section of tooth.	[76]	
7220	Removal of impacted tooth - soft tissue.		[109]
7230	Removal of impacted tooth - partially bony.		[153]
7240	Removal of impacted tooth - completely bony.		[\$184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).		[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures			
7310	Alveoloplasty in conjunction with extractions - per quadrant.		[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.		[96]
Vestibuloplasty			
7340	Vestibuloplasty - ridge extension (secondary epithelialization).		[151]
Surgical Incision			
7510	Incision and drainage of abscess - intraoral soft tissue.		[50]]
[Endodontics			
Pulp Capping			
3110	Pulp cap - direct (excluding final restoration).		[26]
3120	Pulp cap - indirect (excluding final restoration).		[21]
Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration).		[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)			
3310	One canal (excluding final restoration).	\$	[265]
3320	Two canals (excluding final restoration).		[324]
3330	Three canals (excluding final restoration).		[418]
3340	Four or more canals (excluding final restoration).		[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).		[150]
Periapical Services			
3410	Apicoectomy (per tooth) - first root.		[248]]
[Periodontics			
Surgical Services (Including Unusual Postoperative Services)			
4210	Gingivectomy or gingivoplasty - per quadrant.		[105]
4211	Gingivectomy or gingivoplasty - per tooth.		[63]
4220	Gingival curettage, by report.		[42]
4240	Gingival flap curettage (including root planning).		[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.		[315]
Adjunctive Periodontal Services			
4340	Root Planning - entire mouth.		[296]
4341	Root Planning - per quadrant.		[74]
4910	Periodontal Prophylaxis.		[42]]
Adjunctive General Services			
Unclassified Treatment			
9110	Palliative (emergency) treatment of dental pain - minor procedures.		[32]

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510	Inlay, metallic - one surface (excluding gold).	[147]
2520	Inlay, metallic - two surfaces (excluding gold).	[171]
2530	Inlay, metallic - three surfaces (excluding gold).	[204]

Crowns - Single Restorations Only

2710	Crown - Plastic (acrylic).	[50]
2721	Crown - resin with predominantly base metal.	[95]
2740	Crown - porcelain/ceramic substrate. [250]	
2752	Crown - porcelain fused with noble metal.	[224]
2810	Crown - 3/4 cast metallic.	[250]
2830	Crown - Stainless steel.	[275]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]

Vestibuloplasty

7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
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Surgical Incision

7510	Incision and drainage of abscess - intraoral soft tissue.	[50]]
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[Endodontics

Pulp Capping

3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]

Pulpotomy

3220	Therapeutic pulpotomy (excluding final restoration).	[63]
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Root Canal Therapy (Including Treatment Plan, Clinical Procedures,

	and Follow-up Care)	
3310	One canal (excluding final restoration).	\$[265]
3320	Two canals (excluding final restoration).	[324]
3330	Three canals (excluding final restoration).	[418]
3340	Four or more canals (excluding final restoration).	[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]

Periapical Services

3410	Apicoectomy (per tooth) - first root.	[248]]
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[Periodontics

Surgical Services (Including Unusual Postoperative Services)

4210	Gingivectomy or gingivoplasty - per quadrant.	[105]
4211	Gingivectomy or gingivoplasty - per tooth.	[63]
4220	Gingival curettage, by report.	[42]
4240	Gingival flap curettage (including root planning).	[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]

Adjunctive Periodontal Services

4340	Root Planning - entire mouth.	[296]
4341	Root Planning - per quadrant.	[74]
4910	Periodontal Prophylaxis.	[42]]

Prosthodontics (Removable)

Complete Dentures (Including Routine Post Delivery Care)

5110	Complete upper.	[261]
5120	Complete lower.	[259]
5130	Immediate upper.	[289]
5140	Immediate lower.	[277]

Partial Dentures (Including Routine Post Delivery Care)

5211	Upper partial - acrylic base (including any conventional clasps and rests).	[313]
5212	Lower partial - acrylic base (including any conventional clasps and rests).	[315]
5213	Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).	[236]
5214	Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).	[236]
5216	Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).	[315]
5281	Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).	[126]

Adjustments to Dentures

5410	Adjust complete denture - upper (more than six months after installation).	[15]
5411	Adjust complete denture - lower (more than six months after installation).	\$ [16]
5421	Adjust partial denture - upper (more than six months after installation).	[14]
5422	Adjust partial denture - lower (more than six months after installation).	[15]

Repairs to Dentures

5520	Replace missing or broken teeth - complete denture (each tooth)	[42]
5640	Replace broken teeth or denture, no other repairs.	[46]

5650	Add tooth to existing partial denture.	[67]
5660	Add clasp to existing partial denture.	[75]
Denture Reline Procedures		
5730	Reline complete upper denture (chair side).	[58]
5731	Reline complete lower denture (chair side).	[66]
5740	Reline upper partial denture (chair side).	[63]
5741	Reline lower partial denture (chair side).	[63]
5750	Reline complete upper denture (laboratory).	[81]
5751	Reline complete lower denture (laboratory).	[82]
5760	Reline upper partial denture (laboratory).	[84]
5761	Reline lower partial denture (laboratory).	[79]
Other Removable Prosthetic Services		
5820	Temporary partial - stayplate denture (upper).	[193]
5821	Temporary partial - stayplate denture (lower).	[205]
Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)		
Bridge Pontics		
6211	Pontic - cast predominantly base metal.	[197]
6241	Pontic - porcelain fused to predominantly base metal.	[210]
6251	Pontic - resin with predominantly base metal.	[213]
Bridge Retainers - Crowns		
6710	Crown - resin.	[160]
6721	Crown - resin with predominantly base metal.	[171]
6751	Crown - porcelain fused to predominantly base metal.	[210]
6791	Crown - full cast predominantly base metal.	[208]
Other Fixed Prosthetic Services		
6930	Recement bridge.	[42]
6940	Stress breaker.	[101]
Orthodontics (No Scheduled Maximums)		
Minor treatment for tooth guidance		
8110	Upper retainer.	
8112	Lower retainer.	
8120	Fixed appliance therapy.	
Minor treatment to control harmful habits		
8210	Removable appliance therapy.	
8220	Fixed appliance therapy.	
Interceptive orthodontic treatment		
8360	Removable appliance therapy.	
8370	Fixed appliance therapy.	
Comprehensive orthodontic treatment-transitional dentition		
8460	Class I malocclusion.	
8470	Class II malocclusion.	
8480	Class III malocclusion.	

Comprehensive orthodontic treatment-permanent dentition

- 8560 Class I malocclusion.
- 8570 Class II malocclusion.
- 8580 Class III malocclusion.

Other orthodontic procedures

- 8650 Treatment of the atypical or extended skeletal case.
- 8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

- 9220 General anesthesia. \$ [116]

Monitor Life Insurance Company of New York

70 Genesee Street, Utica, NY 13502

Dental Group Application

Group Information

Name of Applicant _____ Federal Id. No: _____

Type of Group _____ Type of Industry _____

Address _____

Number & Street City State Zip Code County
Name of Contact Person: _____ Telephone Number _____

Billing Name & Address (If Different) _____ TPA ☐ No ☐ Yes

Address _____

Number & Street City State Zip Code County

Name of Contact Person: _____ Telephone Number _____

Proposed Effective Date: _____ Length of Contract _____

Census Information

_____ Total Number of Employees _____ Total Number of Eligible Employees

Takeover ☐ No ☐ Yes If yes, previous carrier & takeover period: _____

Type of Coverage ☐ Dental ☐ Vision

Plan Requirements

Eligibility

of Months: _____

Effective

☐ 1st day of the month following completion of eligibility ☐

☐ 1st day of month following date of hire ☐

Waive for initial enrollees? ☐ Yes ☐ No

Who Is Eligible?

☐ All Employees

☐ Class of Employees

(Specify below)

☐ Retired Employees

☐ Spouse

☐ Dependents Children To Age ____

☐ Full Time Students To Age ____

Specified Class _____

Rates

☐ Standard 3 rate: EE \$ _____ Two Party \$ _____ Three Party + \$ _____

Employer Pays

_____ % of Employee; _____ % of Dependent

Employee Pays

_____ % of Employee; _____ % of Dependent

Payment Mode:

☐ Monthly ☐ Biweekly ☐ Weekly

Benefits/Copayments/Deductibles/MaximumsFee Basis: ☐ UCRBased On: ☐ Calendar Year ☐ Contract Year

_____ % Diagnostic & Preventative
 Waive Deductible on D & P? ☐ No ☐ Yes

_____ % Other basic

_____ % Restorative & Denture Repair

_____ % Crowns & Cast Restoration

Waiting Period for C&C? ☐ No ☐ Yes _____Waive on Initial Enrollees? ☐ No ☐ Yes

_____ % Prosthodontics:

Waiting Period for Prosthodontics? ☐ No ☐ Yes _____Waive on Initial Enrollees? ☐ No ☐ YesLifetime Deductible ☐ No ☐ Yes

Individual Deductible \$ _____

Family Aggregate Deductible \$ _____

Maximum \$ _____

Missing Tooth Exclusion ☐ No ☐ Yes, only teeth extracted
 under contract will be covered.

Add Orthodontics to Covered Services? ☐ No ☐ Yes

If Yes, Supply the Following Details:

Children Only ☐ To Age _____

Copayment _____%

Lifetime Maximum \$ _____

Takeover on Max ☐ No ☐ YesWaiting Period for Orthodontics? ☐ No ☐ YesWaive on Initial Enrollees? ☐ No ☐ Yes**Administrative Information** _____

Initial Eligibility Information Will Be Provided By:

☐ Enrollment Cards☐ Other (specify) _____

Additions and Deletions Following Initial Enrollment

Will Be Provided By:

☐ Enrollment Cards☐ Other (specify) _____**Billing Information** _____Provide a Printed Copy of Billing to Group ☐ No ☐ YesPay as Billed ☐ No ☐ Yes

Payment Methods (Check those that apply)

☐ Check☐ Wire Transfer☐ Other (specify) _____**Special Requests** (Attach Page if Necessary) _____

Agent Name _____ TIN or SS# _____ State License # _____

(If applicable)

Signature _____ Telephone # _____

Address _____

(Street)

(City)

(State)

(Zip)

(County)

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Monitor Life Insurance Company of New York. The statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Monitor Life Insurance Company of New York, we would not in good faith have issued the contract at the same premium rate. *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

Executed this _____ day of _____, 20____ for the Applicant By:

at (city/state) _____

Name & Title _____

(please print)

Signature _____

Accepted by

Monitor Life Insurance Company of New York

This _____ Day of _____, 20____

Underwriting Authorization _____ (initials)

David R. White, Underwriter

Monitor Life Insurance Company of New York

70 Genesee Street, Utica, NY 13502

Dental Group Application

Group Information

Name of Applicant _____ Federal Id. No: _____

Type of Group _____ Type of Industry _____

Address _____

Number & Street City State Zip Code County
Name of Contact Person: _____ Telephone Number _____

Billing Name & Address (If Different) _____ TPA ☐ No ☐ Yes

Address _____

Number & Street City State Zip Code County

Name of Contact Person: _____ Telephone Number _____

Proposed Effective Date: _____ Length of Contract _____

Census Information

_____ Total Number of members _____ Total Number of Eligible members

Takeover ☐ No ☐ Yes If yes, previous carrier & takeover period: _____

Type of Coverage ☐ Dental ☐ Vision

Plan Requirements

Eligibility

of Months: _____

Effective

☐ 1st day of the month following completion of eligibility ☐

☐ 1st day of month following date of hire ☐

Waive for initial enrollees? ☐ Yes ☐ No

Who Is Eligible?

☐ All members

☐ Class of members
(Specify below)

☐ Retired members

☐ Spouse

☐ Dependents Children To Age ____

☐ Full Time Students To Age ____

Specified Class _____

Rates _____

☐ Standard 3 rate: Member \$ _____ Two Party \$ _____ Three Party + \$ _____

Association Pays

_____ % of member; _____ % of dependent

Member Pays

_____ % of member; _____ % of dependent

Payment Mode:

☐ Monthly ☐ Biweekly ☐ Weekly

Benefits/Copayments/Deductibles/MaximumsFee Basis: ☐ UCRBased On: ☐ Calendar Year ☐ Contract Year

_____ % Diagnostic & Preventative
 Waive Deductible on D & P? ☐ No ☐ Yes

_____ % Other basic

_____ % Restorative & Denture Repair

_____ % Crowns & Cast Restoration

Waiting Period for C&C? ☐ No ☐ Yes _____

Waive on Initial Enrollees? ☐ No ☐ Yes

_____ % Prosthodontics:

Waiting Period for Prosthodontics? ☐ No ☐ Yes _____

Waive on Initial Enrollees? ☐ No ☐ Yes

Lifetime Deductible ☐ No ☐ Yes

Individual Deductible \$ _____

Family Aggregate Deductible \$ _____

Maximum \$ _____

Missing Tooth Exclusion ☐ No ☐ Yes, only teeth extracted
 under contract will be covered.

Add Orthodontics to Covered Services? ☐ No ☐ Yes

If Yes, Supply the Following Details:

Children Only ☐ To Age _____

Copayment _____%

Lifetime Maximum \$ _____

Takeover on Max ☐ No ☐ YesWaiting Period for Orthodontics? ☐ No ☐ YesWaive on Initial Enrollees? ☐ No ☐ Yes**Administrative Information** _____

Initial Eligibility Information Will Be Provided By:

☐ Enrollment Cards

☐ Other (specify) _____

Additions and Deletions Following Initial Enrollment

Will Be Provided By:

☐ Enrollment Cards

☐ Other (specify) _____

Billing Information _____Provide a Printed Copy of Billing to Group ☐ No ☐ YesPay as Billed ☐ No ☐ Yes

Payment Methods (Check those that apply)

☐ Check

☐ Wire Transfer

☐ Other (specify) _____

Special Requests (Attach Page if Necessary) _____

Agent Name _____ TIN or SS# _____ State License # _____

(If applicable)

Signature _____ Telephone # _____

Address _____

(Street)

(City)

(State)

(Zip)

(County)

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Monitor Life Insurance Company of New York. The statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Monitor Life Insurance Company of New York, we would not in good faith have issued the contract at the same premium rate. *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

Executed this _____ day of _____, 20____ for the Applicant By:

at (city/state) _____

Name & Title _____

(please print)

Signature _____

Accepted by

Monitor Life Insurance Company of New York

This _____ Day of _____, 20____

Underwriting Authorization _____ (initials)

David R. White, Underwriter

MONITOR LIFE INSURANCE COMPANY OF NEW YORK^{ML}

Utica, NY 13502 - Dental Application

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>

- ☐ New Application
☐ Change Card

Home Address	City, ST	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Phone	Employer/Group /Association	Emp/Grp/Assoc.Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Select Payment Mode

- ☐ Group Billing
☐ Annual Direct Billing
☐ Semi Annual Direct Billing
☐ Quarterly Direct Billing
☐ Monthly Bank Draft

Primary Employee/Member	SSN	DOB	Marital Status	Sex
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Dependent Name	DOB	Relationship	Sex	Student (Y/N)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

This authorization will draft monthly payments from my checking account. A voided blank check is enclosed on the bank on which the drafts are to be drawn.

Monthly Credit Card

- ☐ Visa
☐ Master Card

Credit Card #

Exp. Date

***Are all dependent children between the ages 19 and 24 full-time students (Y/N)** "I understand and agree that the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Certificate." California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Signature of Employee/Member	Check with Application? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Eff. Date	Plan Code STDENT
Agent Sign And Complete		Group Code	Rate Code	Rate

ML-ALL-STATES -DENTAL-APP-1(10/05)

06/2010

SERFF Tracking Number:	AMFT-126726824	State:	Arkansas
Filing Company:	Monitor Life Insurance Company of New York	State Tracking Number:	46430
Company Tracking Number:	ML-POL-DENT (10/05) AR		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Group Dental		
Project Name/Number:	ML-POL-DENT (10/05)/ML-POL-DENT (10/05)		

Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item: Flesch Certification	Approved-Closed	08/13/2010
Comments:		
Attachments:		
AR Imp Information Notice.pdf		
Generic readability-certification-MLIFE.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Application	Approved-Closed	08/13/2010
Comments:		
See Form Schedule Tab for applications.		

	Item Status:	Status
		Date:
Satisfied - Item: Filing Authorization Letter	Approved-Closed	08/13/2010
Comments:		
Attachment:		
ML Authorization Letter 2010 (2).pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Prior Approval of Associations	Approved-Closed	08/13/2010
Comments:		
Attachments:		
PriorAppr-AR-BAIAssoc.pdf		
PriorAppr-WTA.pdf		

**IMPORTANT INFORMATION FOR
ARKANSAS POLICYOWNERS**

If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:

Monitor Life Insurance Company of New York
Administrative Office:
P.O. Box 14067
Jackson, Mississippi 39236

Telephone: 1-800-252-3439

Agent _____
Address _____

Telephone _____

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494
1-501-371-2640

E-Mail: Insurance@mail.state.ar.us
Web Site: www.state.ar.us/insurance

ML-NOTICE-AR

August 9, 2010

State of Arkansas

Re: Readability Certification for Policy Forms

To Whom It May Concern:

Pursuant to Statutes and Regulations and within the authorization granted to Lewis & Ellis, Inc. to file products on behalf of Monitor Life Insurance Company of New York, I hereby certify that the policy forms contained within this filing achieved the following scores:

Form Number	Flesch Score
ML-POL-DENT (10/05)	50.4
ML-ECERT-DENT (10/05)	53.8
ML-MCERT-DENT (10/05)	52.4
ML-DENTAL ER GPAPP(10/05)	52.8
ML-DENTAL ASSOC GPAPP(10/05)	61.3
ML-ALL-STATES-DENTAL-APP-1(10/05)	53.5



Rebecca Ewing, FLMI, HIA, ACS, ACP
Lewis & Ellis, Inc. – Actuaries and Consultants
Independent Compliance Consultant



MONITOR LIFE
INSURANCE COMPANY OF NEW YORK

April 26, 2010

To: All State Insurance Department Personnel


Re: Premium Saver and Dental Insurance Policies
Monitor Life Insurance Company of New York

Monitor Life Insurance Company of New York (Monitor Life) authorizes Lewis & Ellis, Inc. to submit the above captioned forms on Monitor Life's behalf. Under this authorization Lewis & Ellis, Inc. has the authority to:

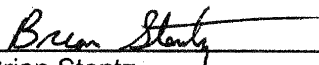
1. Represent Monitor Life in the submission and negotiation of approval of the above forms and related rates
2. Give assurances and make commitments on behalf of Monitor Life regarding specific conditions of the approval of above forms and related rates

However, no authority is granted which permits Lewis & Ellis, Inc. to withdraw or modify any existing forms on file with your department.

Subject to the foregoing, the signature of:

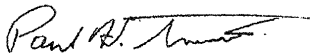

Cabe Chadick, FSA, MAAA
Senior Vice President & Principal


Rebecca Ewing
Compliance Consultant

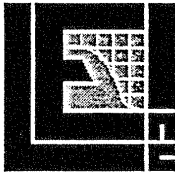

Brian Stentz
Actuarial Associate

When affixed to a letter or certification on intent, will be as binding as if signed by an officer of Monitor Life Insurance Company of New York.

Sincerely,



Paul H. Trevett
President & CEO



Lewis & Ellis, Inc.
Actuaries & Consultants

RECEIVED

APR 17 2000

April 10, 2000

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Ms. Rosalind D. Minor
Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 77201-1904

Re: Standard Life and Accident Insurance Company
Group Dental Policy
MS-POL-DENT (03/00), et al
Replacement of Previously Approved Forms

APPROVED
APR 17 2000
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Dear Ms. Minor,

Please find enclosed a submission of the following forms for review and approval:

<u>Form #</u>	<u>Description</u>
AR-POL-DENT (03/00)	Group Dental Master Policy
AR-MCERT- DENT (03/00)	Group Dental Certificate for Association Members
AR-ECERT-DENT (03/00)	Group Dental Certificate for Employees

These forms will replace the previously approved forms AR-POL-UCR (01/99), AR-ECERT-UCR (09/99), and AR-MCERT-UCR (01/99)

Form Description

This form is a group dental policy. The master policy form will be issued to two different group types. First, the new master policy will be issued to employers in the state of Arkansas along with the new employee certificate AR-ECERT-DENT. Second, the master policy will be issued to eligible associations, specifically a national trade association in the state of Mississippi. This specific association, Benefits Association, Inc. has been approved and registered in and by the state of Mississippi. The new member certificate that will be issued is AR-MCERT-DENT.

Dallas

Glenn A. Tobleman, F.S.A., F.C.A.S.
Robert E. DeGeeter, F.S.A.
Charlie R. Allison, F.S.A.
S. Scott Gibson, F.S.A.
Steven D. Bryson, F.S.A.
Dick L. Phillips, F.S.A.
Cabe W. Chadick, F.S.A.
Lawrence G. Scott, A.S.A.
Michael A. Mayberry, A.S.A.
Shawn T. Loftus, A.S.A.
Dawn M. Epping, E.A.

Kansas City

Richard L. Files, F.S.A.
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
Roger K. Annin, F.S.A.
David L. Batchelder, A.S.A.
Leon L. Langlitz, F.S.A.
Gary R. McElwain, FLMI
Christopher H. Davis, F.S.A.

Marketing

Licensed brokers and agents of the company will sell the association group coverage to association members. For the group employer market, the master policy will be issued to employers typically with ten employees or more. For the association business, Standard Life will guarantee issue coverage for all verifiable members of each association written a policy. Such members include individuals as well as small group employers with less than 10 employees.

Modifications

The two major modifications to the previously approved form are:

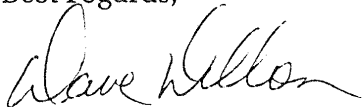
- Combining the master policy for the Arkansas issued groups (employer and association groups) into one master policy.
- Adding a provision that will allow the possibility of having a scheduled maximum benefits for the procedures covered.

We have included the following filing materials (in duplicate):

- The above policy forms
- \$50 filing fee
- Filing Authorization
- Copy of Association bylaws and other material (which is the same as what was filed with the previous forms)
- Copy of Mississippi's Approval (Please note that this is for the previous form. We are currently in the process of replacing these forms in Mississippi also.)
- Self-addressed stamped envelope

We appreciate your time and consideration. If you have any questions, please call me at (972)699-2700.

Best regards,



Dave Dillon
Actuarial Analyst

Enclosures

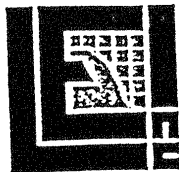
We have received your filing regarding the above named discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
2. Is this group incorporated? If so, give state of incorporation.
3. Is there a current office in Arkansas?
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.
5. Are annual dues charged? If so, specify amount.
6. What are the specific activities of the organization?
7. What benefits are provided to the members in addition to insurance?
8. What qualifies an individual for membership?
9. How are members recruited? If by mailing list, advise the source of this list.
10. Attach a copy of the organization by-laws.
11. Also, enclose a current list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
12. Please attach a copy of the organization's most recent financial statement.
13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members.

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

Answers to Questions of the Arkansas Insurance Department
related to
Benefits Association, Inc.

1. Benefits Association, Inc., P.O. Box 12665, Jackson, Ms. 39236
2. Incorporated in the State of Mississippi, Certificate Attached
3. No current office in Arkansas.
4. No officers, chapters, or committees in Arkansas at this time.
5. Annual dues are \$12 per year
6. The purpose of the organization is listed in the organization purpose which is attached.
7. The benefits of the association are listed in the same page as the organizational purpose. We have enclosed one of our benefit packages to new members and one of our newsletters for the Department to see.
8. In order to qualify for membership a person must be a small business owner, or employee, retirees, or dependents of employees of small independent businesses.
9. Members are recruited through the mail mainly. We use the American Business Information Mailing Lists, The American Yellow Pages (a CD-ROM lists which is made by CD USA), and the National Federation of Independent Business. We also use some smaller lists such as the 1998-99 Register of the Affluent
10. The organizational by-laws are attached.
11. Currently, we have no dues paying members in Arkansas. The Association was only registered to do business in Arkansas on June 25, 1998. We wanted all of our benefits in place before we began to market in Arkansas. Our membership at this point is in Mississippi and the main membership is in Florida.
12. Attached is copy of the Association's most recent monthly statement.
13. The Association receives no compensation of any kind from the insurer issuing the contracts to its members.



Lewis & Ellis, Inc.
Actuaries & Consultants

Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
Robert E. DeGoeter, F.S.A.
Charlie R. Allison, F.S.A.
S. Scott Gibson, F.S.A.
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Dawn M. Epping, E.A.

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Terry M. Long, F.S.A.
Roger K. Annin, F.S.A.
David L. Batchelder, A.S.A.
Leon L. Langtitz, F.S.A.
Gary R. McElwain, FLMI
Christopher H. Davis, F.S.A.

APPROVED AND FILED

November 23, 1999

DEC 13 1999

GEORGE DALE, COMMISSIONER
MISSISSIPPI DEPARTMENT OF INSURANCE
By Latta, Langston & Dyer, Consulting Actuaries

Of Counsel

William H. Lewis, Jr., F.S.A.
J. Daniel Ellis, F.S.A.

Mr. Harland Dyer
Mississippi Department of Insurance
P.O. Box 79
Jackson, Mississippi 39205

Re: Resubmission
Group Association Dental Filing for Standard Life and Accident Company
NAIC # 86355, State of Mississippi Company # 7701327
MS-POL-UCR (01/99), et al

Dear Mr. Dyer:

We have enclosed for your review and approval a resubmission of the policy form for a group association dental policy.

Enclosed is the new Member Certification MS-MCERT-UCR (01/99) which complies with Section 83-9-5 of the Mississippi Code. The Time of Payment section on page 15 of the certification should now comply. Section 6.06 of the policy of the Master Policy should already be in compliance.

Enclosed are the following materials:

- Group Master Policy MS-POL-UCR (01/99) (in duplicate)
- Member certificate of coverage MS-MCERT-UCR (01/99) (in duplicate)
- Postage-paid return envelope
- Copy of previous correspondence

Please give us a call if you have any questions or comments regarding this material.

Sincerely,

Dave Dillon
Actuarial Analyst

RECEIVED

DEC 06 1999

INSURANCE DEPT.

STATE OF MISSISSIPPI

SECRETARY OF STATE'S OFFICE

ERIC CLARK
SECRETARY OF STATE
JACKSON, MISSISSIPPI

CERTIFICATE

I, Eric Clark, Secretary of State of the State of Mississippi, and as such, the legal custodian of the corporate records, required by the laws of Mississippi, to be filed in my office, do hereby certify as follows:

That on January 4, 1990, the State of Mississippi issued a non-profit charter to BENEFITS ASSOCIATION, INC.

That the registered office of said corporation is located at 633 North State Street, Jackson, Mississippi, and the registered agent at that address is Stephen M Roberts.

That on December 14, 1992, articles of amendment were filed changing its name to NATIONAL TRAVELERS INFORMATION ASSOCIATION, INC.

That on May 23, 1997, articles of amendment were filed changing its name to BENEFITS ASSOCIATION, INC.

That insofar as the records of this office are concerned, the said BENEFITS ASSOCIATION, INC. is in good standing at this time.

Witness my hand and seal of office, this the
28th day of May 1997



SECRETARY OF STATE



Benefits Association, Inc.

Benefits Association, Inc. was incorporated on January 4, 1990 as a non-profit Mississippi corporation. The Association's main office is located at, 407 Briarwood Drive, Suite 201, Jackson, Mississippi 39206.

The Association presently has over 6,000 members nationally.

The purpose of the Association is to serve as a professional trade association to promote and provide of the general welfare of the small business owners and their employees, retirees and their dependents who become association members. It shall seek to attain these purposes by making available to them such services and benefits, financial or otherwise, which may be approved from time to time by the Association's Board of Directors. Such services and benefits may, but not, include any of the following, which are illustrative only, and not to be considered a limitation on the general purposes of the Association:

- A. Purchase of merchandise and services at group discount rates;
- B. Premium offers;
- C. Access to discounted legal and accounting services;
- D. Welfare benefit assistance through insurance or other programs;
- E. Access and discounts to telecommunications and computer on-line services;
- F. Self-marketing support systems;
- G. Travel assistance and discounts; and
- H. Publication of a periodic newsletter featuring articles consistent with its purposes.

AMENDED AND RESTATED BYLAWS OF
BENEFITS ASSOCIATION, INC.
A NON-PROFIT MISSISSIPPI CORPORATION

ARTICLE I. OFFICES

SECTION 1. Principal Office. The principal office of the corporation in the State of Mississippi shall be located in the City of Jackson, County of Hinds. The corporation may have such other offices, either within or without the State of Mississippi, as the board of directors may designate or as the business of the corporation may require from time to time.

SECTION 2. Registered Office. The corporation shall continuously maintain in the State of Mississippi a registered office that may be the same as its principal office, and a registered agent as required by the Mississippi Nonprofit Corporation Act. The address of the registered office may be changed from time to time by the board of directors.

ARTICLE II. MEMBERS

SECTION 1. Membership Requirements. The corporation shall have two classes of members: Type One members and Type Two members (collectively referred to as "Members"). Type One Members shall be persons who are independent business owners or their employees, and their dependents. Type Two Members shall be former employees or retirees and their dependents of these independent business owners. Type Two Members may be senior citizens. Members must sign an application for membership which is then executed by the Secretary and pay the first month's dues. Members shall receive a Certificate of Membership and Membership I.D. Card.

SECTION 2. Vote. The general Membership of the corporation shall not be entitled to vote.

SECTION 3. Certificate Non-Assignable. The Certificate of Membership and the rights and privileges of a Member shall not be assignable.

SECTION 4. Death or Dissolution of Member. Upon the death or dissolution of any Member, the Certificate of Membership shall automatically cease.

SECTION 5. Resignation. Any Member may withdraw from the corporation after fulfilling all obligations to it by giving written notice of such intention to the Secretary, which notice shall be presented to the Board of Directors by the Secretary at the first meeting after its receipt.

SECTION 6. Suspension and Expulsion. A Member may be suspended for a period or expelled for cause such as violation of the by-laws or rules of the corporation, or for conduct prejudicial to the best interest of the corporation. Suspension or expulsion shall be by a two-thirds (2/3) vote of the membership of the Board of Directors, provided that a statement of the charges shall have been mailed by registered mail to the Member at his last recorded address at least thirty (30) days before final action is taken thereon, this statement shall be accompanied by a notice of the time, when and place where the Board of Directors is to take action in the premises. The Member shall be given an opportunity to present a defense at the time and place mentioned in such notice.

ARTICLE III. PURPOSES

The purpose of the corporation shall be to promote the health and dental maintenance and fitness education among Members of the corporation, some of which are senior citizens; to assist the Members in leading a happier and healthier life; to secure, preserve, diffuse and interchange accurate and reliable information for the Members; to establish and foster efficient purchasing by the Members; to further cooperative action by those engaged in business as employers and employees; to disseminate all types of information by appropriate means; to promote and advance the mutual interests of the Members; to foster exchange of ideas between the Members; to provide information and guidance in order to aid and maintain the physical health and mental condition of Members; and, without limitation, to do and perform all things consistent with the foregoing.

ARTICLE III. POWERS

To do any and all things and exercise any and all powers, rights and privileges which the corporation may now or hereafter be authorized to do under the Mississippi Nonprofit Corporation Act, or under any act amendatory thereof, supplemental thereto, or substituted therefor.

ARTICLE IV. FISCAL YEAR

The fiscal year of the corporation shall be the first day of January and end on the last day of December in each year.

ARTICLE V. DUES

SECTION 1. Annual Dues. Board of Directors shall determine from time to time the amount of annual dues payable to the corporation by Members.

SECTION 2. Payment of Dues. Dues shall be payable in advance on the first day of January in each fiscal year. Dues may be prorated, at the election of the Board of Directors, from the first day of the month in which such new Member is elected to membership, for the remainder of the fiscal year of the corporation.

SECTION 3. Default and Termination of Membership. When any Member shall be in default of the payment of dues for a period of three months from the beginning of the fiscal year or period for which such dues became payable, his membership may thereupon be terminated by the Board of Directors in the manner provided by Article II, Section 6 of these By-Laws.

ARTICLE VI. MEETINGS

SECTION 1. Annual Meetings. There shall be an annual meeting on the third Monday of October in each year, or such other time as the board of director may from time to time select, for receiving the annual reports of officers, directors and committees, and the transaction of other business. If the day designated falls upon a legal holiday, the meeting shall be held on the next succeeding secular day not a holiday. Notice of the meeting, signed by the Secretary, shall be mailed, except as herein or by statute otherwise provided, to the last recorded address of each Member at least ten days and not more than fifty days before the time appointed for the meeting. All notices of meetings shall set forth the place, date, time and purpose of the meeting.

SECTION 2. Special Meetings. Special meetings may be called by the Board of Directors at their discretion. Notice of any special meeting is to be given in the same manner for the annual meeting. No business other than that specified in the notice of meeting shall be transacted at any special meeting of the Members of the corporation.

SECTION 3. Quorum. The presence in person or by proxy of five (5) Members of the corporation entitled to vote shall be necessary to constitute a quorum for the transaction of business.

SECTION 4. Order of Business. The order of business of the annual meeting of the Members insofar as possible at all other meetings of the Members shall be essentially as follows:

- (1) Called to order by the President;
- (2) Reading of the Minutes of the previous meeting of the Members and taking of action necessary thereon;
- (3) Appointment of directors;
- (4) Presentation and consideration of, and acting upon, reports of officers, directors and committees;
- (5) Pending business;
- (6) New business;
- (7) Adjournment.

ARTICLE VII. DIRECTORS

SECTION 1. General Powers. The business and affairs of the Company shall be managed by a board of five directors which shall exercise all of the powers of the Company except such as are by law or by the Certificate of Incorporation of the

Company or by these By-Laws conferred upon or reserved to the Members. The incorporators shall constitute the initial Board of Directors, and are empowered to appoint additional directors in constituting a three Member board.

SECTION 2. Qualifications and Tenure. At each annual meeting of the Members in which an election is to occur, directors shall be elected from the membership by the Members to serve until their successor shall have been elected and qualified. The incorporators shall serve as the initial Board of Directors until their successors are duly elected and qualified as herein provided. At the Organizational Meeting of the Members, directors shall be elected for initial terms of two years each; thereafter directors shall be elected for a term of five years. No person shall be eligible to become or remain a director who is not a bona fide Member of the Company. Nothing in this section contained shall, or shall be construed to, affect in any manner whatsoever the validity of any action taken at any meeting of the Board of Directors.

SECTION 3. Nominations. (a) It shall be the duty of the Board of Directors to cause to be nominated, certain Members of the Company for the position of Directors of the Company, and the Board shall prepare and post at the principal office of the Company at least twenty (20) days before the meeting a list of nominees for Directors.

(b) Nothing contained herein shall prevent additional nominations being made from the floor at the meeting of the Members.

(c) Notwithstanding anything otherwise contained in this section, failure to comply with any of the provisions of this section shall not affect in any manner whatsoever the validity of any election of Directors or officers.

SECTION 4. Vacancies. Vacancies occurring in the Board of Directors shall be filled by a majority vote of the remaining Directors, and Directors thus elected shall serve for the remainder of the unexpired term for which the vacated Director was elected, and until their successors shall have been elected.

SECTION 5. Expenses of Directors. The Directors shall be entitled to reimbursement for expenses incurred by them in the performance of their duties.

SECTION 6. Rules and Regulations. The Board of Directors shall have power to make and adopt such rules and regulations, not inconsistent with law, the Certificate of Incorporation of the Company or these By-Laws, as it may deem advisable for the management, administration, regulation, and conduct of the business and affairs of the Company.

ARTICLE VIII. MEETING OF DIRECTORS

SECTION 1. Regular Meetings. A regular meeting of the Board of Directors shall be held without notice other than this By-Law, immediately after and at the same place, as the annual meeting of the Members. Regular meetings of the Board of Directors shall

Company or by these By-Laws conferred upon or reserved to the Members. The incorporators shall constitute the initial Board of Directors, and are empowered to appoint additional directors in constituting a three Member board.

SECTION 2. Qualifications and Tenure. At each annual meeting of the Members in which an election is to occur, directors shall be elected from the membership by the Members to serve until their successor shall have been elected and qualified. The incorporators shall serve as the initial Board of Directors until their successors are duly elected and qualified as herein provided. At the Organizational Meeting of the Members, directors shall be elected for initial terms of two years each; thereafter directors shall be elected for a term of five years. No person shall be eligible to become or remain a director who is not a bona fide Member of the Company. Nothing in this section contained shall, or shall be construed to, affect in any manner whatsoever the validity of any action taken at any meeting of the Board of Directors.

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SECTION 6. Rules and Regulations. The Board of Directors shall have power to make and adopt such rules and regulations, not inconsistent with law, the Certificate of Incorporation of the Company or these By-Laws, as it may deem advisable for the management, administration, regulation, and conduct of the business and affairs of the Company.

ARTICLE VIII. MEETING OF DIRECTORS

SECTION 1. Regular Meetings. A regular meeting of the Board of Directors shall be held without notice other than this By-Law, immediately after and at the same place, as the annual meeting of the Members. Regular meetings of the Board of Directors shall

also be held at such time and place as the Board of Directors may provide by resolution. Such regular meetings may be held without notice other than such resolution fixing the time and place thereof.

SECTION 2. Special Meetings. Special meetings of the Board of Directors may be called by the President or any five (5) directors. The person or persons authorized to call special meetings of the Board of Directors may fix the time and place for the holding of any special meeting of the Board of Directors called by them.

SECTION 3. Notice. Notice of the time, place and purpose of any special meeting of the Board of Directors shall be given at least five (5) days previous thereto, by written notice, delivered personally or mailed, to each director at his last known address. If mailed, such notice shall be deemed to be delivered when deposited in the United States Mail to addressee, with postage thereon prepaid.

SECTION 4. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, provided, that if less than a majority of the Directors are present at said meeting a majority of the Directors present may recess the meeting from time to time without further notice.

SECTION 5. Manner in Acting. The act of the majority of the Directors present at a meeting at which a quorum is present shall be the act of the entire Board of Directors.

ARTICLE IX. OFFICERS

SECTION 1. Number. The officers of the Company shall be a President, Vice-President, Secretary and Treasurer and such other offices as the Board of Directors may from time to time appoint. The offices of Secretary and of Treasurer may be held by the same person.

SECTION 2. Election and Term of Office. The officers shall be elected by ballot annually by and from the Board of Directors at the first meeting of the Board of Directors held after each annual meeting of the Members. If the election of officers shall not be held at such meeting, such election shall be held as soon thereafter as conveniently may be. Each officer shall hold office until the first meeting of the Board of Directors following the next succeeding annual meeting of the Members or until this successor shall have been duly elected and shall have qualified subject to the provisions of these By-Laws with respect to the removal of officers.

SECTION 3. Removal. Any officer or agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interest of the Company will be served thereby.

SECTION 4. Vacancies. Except as otherwise provided in these By-Laws, a vacancy in any office may be filled by the Board of Directors for the unexpired portion of the term.

SECTION 5. President. The president:

- (a) shall preside at all meetings of the Members and of the Board of Directors;
- (b) shall sign any deed, mortgage, deed of trust, note, bond, contract or other like or unlike instrument authorized by the Board of Directors to be executed, except in cases in which the signing and execution thereof shall be expressly delegated by the Board of Directors or by these By-Laws to some other officer or agent of the Company, or shall be required by law to be otherwise signed or executed; and,
- (c) in general shall perform all duties incident to the office of president and such other duties as may be prescribed by the Board of Directors from time to time.

SECTION 6. Vice-President. In the absence of the President, or in the event of his inability or refusal to act, the Vice-President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President and shall perform such other duties as from time to time may be assigned to him by the Board of Directors.

SECTION 7. Secretary. The Secretary shall:

(a) keep the minutes of the meetings of the Members and the Board of Directors in one or more books provided for that purpose, and see that all notices are duly given in accordance with these By-Laws, or as required by law; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to him by the Board of Directors;

(b) have general charge of the books of the Company in which a record of the Members is kept; and be custodian of the corporate records and of the seal of the Company and see that the seal of the Company is affixed to all documents, the execution of which on behalf of the Company under its seal is duly authorized in accordance with the provisions of these By-Laws; and,

(c) keep on file at all times a complete copy of the By-Laws of the Company containing all amendments thereto, which copy of the By-Laws shall always be open to the inspection of any Member, and at the expense of the Company, forward a copy of the By-Laws and of all amendments thereto to each Member upon written request.

SECTION 8. Treasurer. The Treasurer shall:

(a) have charge and custody of and be responsible for all funds and securities of the Company and receive and give receipts for money due and payable to the Company from any sources whatsoever and deposit all such monies in the name of the Company in such bank or banks as shall be selected in accordance with the provisions of these By-Laws; and,

(b) in general perform all the duties incident to the office of Treasurer and such other duties as from time to time may be assigned to him by the Board of Directors.

ARTICLE X. CONTRACTS, CHECKS AND DEPOSITS

SECTION 1. Contracts. Except as otherwise provided in these By-Laws, the Board of Directors may authorize any officer or officers, agent or agents to enter into any contract, or execute and deliver any instrument in the name of and for and on behalf of the Company and such authority may be general or confined to specific instances.

SECTION 2. Checks, Drafts, Etc. All checks, drafts or other orders for the payment of money and all notes, bonds or other evidence of indebtedness issued in the name of the Company shall be signed by such officer or officers of the Company and in such manner as shall from time to time be determined by resolution of the Board of Directors.

SECTION 3. Deposits. All funds of the Company shall be deposited from time to time to the credit of the Company in such bank or banks as the Board of Directors may select.

ARTICLE XI. WAIVER OF NOTICE

Any Member or director may waive, in writing any notice of meeting required to be given by these By-Laws.

ARTICLE XII. AMENDMENTS

These By-Laws may be altered, amended or repealed by the affirmative vote of not less than two-thirds (2/3) of all the Directors at any regular or special meeting, provided the notice of such meeting shall have contained a copy of the proposed alteration, amendment or repeal.

ACCEPTED THIS 23RD of May, 1997.

By: Lynn S. White
Lynn S. White
TITLE: President

UNANIMOUS CONSENT TO ACTION BY
THE DIRECTORS OF
BENEFITS ASSOCIATION, INC.
IN LIEU OF A SPECIAL MEETING
OF THE DIRECTORS

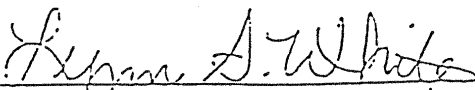
The undersigned, constituting all of the directors of the captioned corporation, a Mississippi corporation, do hereby consent to the following actions undertaken in the name of and on behalf of the directors of the corporation, without the necessity of a meeting, in lieu of a special meeting of the board of directors:

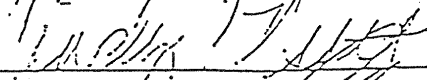
Authorize Amendments to Bylaws

WHEREAS: It has been necessary for the corporation to amend and restate the Bylaws in the form attached hereto as Exhibit "A";

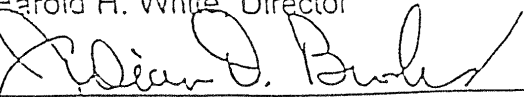
THEREFORE, BE IT RESOLVED: That, pursuant to Article XIV of the Bylaws of the corporation which governs amendments to the Bylaws of the corporation, the Bylaws of the corporation are hereby amended and approved as set forth in Exhibit "A" attached hereto.

The undersigned, constituting all of the members and directors of the corporation, have executed this unanimous consent to action as of the 23rd day of May, 1997.


Lynn S. White, Director


Cindy C. Nutt, Director


Harold H. White, Director


Julian D. Brooks, Director


David R. White, Director

BENEFITS ASSOCIATION, INC.

FINANCIAL STATEMENT

October 1, 1998

Unaudited

ASSETS

Cash on hand and in Banks	\$11,500
Accounts and Notes Receivable	4,750

Total Assets	\$16,250
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LIABILITIES

Accounts and Bills Dues	\$ 3,630
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Excess Assets over Liabilities	\$12,620
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SERFF Tracking Number: LWEL-125610666 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 38738
 Company Tracking Number: 0282-0706
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: World Travelers Association
 Project Name/Number: World Travelers Association - Group Dental Plan/0282-0706

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: World Travelers Association SERFF Tr Num: LWEL-125610666 State: Arkansas
 TOI: H10G Group Health - Dental SERFF Status: Closed-Approved- State Tr Num: 38738
 Closed

Sub-TOI: H10G.000 Health - Dental Co Tr Num: 0282-0706 State Status: Approved-Closed
 Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
 Author: Rebecca Ewing Disposition Date: 04/22/2008
 Date Submitted: 04/17/2008 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

General Information

Project Name: World Travelers Association - Group Dental Plan
 Project Number: 0282-0706
 Requested Filing Mode:
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 04/22/2008
 Company Status Changed:
 Deemer Date:
 Submitted By: Rebecca Ewing
 Filing Description:
 World Travelers Association, Inc. - Group Dental Plan

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Group Market Type: Association
 Explanation for Other Group Market Type:
 State Status Changed: 04/22/2008
 Created By: Rebecca Ewing
 Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Rebecca Naderi, Compliance Consultant rnaderi@lewisellis.com
 2929 N. Central Expy., Ste. 200 972-850-3272 [Phone]
 Richardson, TX 75085-1857 972-850-3273 [FAX]

Filing Company Information

(This filing was made by a third party - lewisandellisincorporated)

SERFF Tracking Number: LWEL-125610666 State: Arkansas

Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 38738

Company Tracking Number: 0282-0706

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: World Travelers Association

Project Name/Number: World Travelers Association - Group Dental PPlan/0282-0706

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Oklahoma

One Moody Plaza Group Code: 408 Company Type:

Galveston, TX 77550-7999 Group Name: State ID Number:

(409) 766-6959 ext. [Phone] FEIN Number: 73-0994234

Filing Fees

Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$50.00	04/17/2008	19654541

SERFF Tracking Number: *LWEL-125610666* *State:* *Arkansas*
Filing Company: *Standard Life and Accident Insurance Company* *State Tracking Number:* *38738*
Company Tracking Number: *0282-0706*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *World Travelers Association*
Project Name/Number: *World Travelers Association - Group Dental PPlan/0282-0706*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/22/2008	04/22/2008

SERFF Tracking Number: *LWEL-125610666* *State:* *Arkansas*
Filing Company: *Standard Life and Accident Insurance Company* *State Tracking Number:* *38738*
Company Tracking Number: *0282-0706*
TOI: *H10G Group Health - Dental* *Sub-TOI:* *H10G.000 Health - Dental*
Product Name: *World Travelers Association*
Project Name/Number: *World Travelers Association - Group Dental PPlan/0282-0706*

Disposition

Disposition Date: 04/22/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LWEL-125610666 State: Arkansas
 Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 38738
 Company Tracking Number: 0282-0706
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: World Travelers Association
 Project Name/Number: World Travelers Association - Group Dental PPlan/0282-0706

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document	World Travelers Association, Inc.	Approved-Closed	Yes

SERFF Tracking Number: LWEL-125610666 State: Arkansas
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 38738
Company Tracking Number: 0282-0706
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: World Travelers Association
Project Name/Number: World Travelers Association - Group Dental Plan/0282-0706

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Certification/Notice	Approved-Closed	04/22/2008
Bypass Reason: This filing is not for actual forms, but is for review/approval of an association, the World Travelers of America, Inc.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	04/22/2008
Bypass Reason: No application for this filing. This is for review of association material.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Submission Letter	Approved-Closed	04/22/2008
Comments:		
Attachment: subltr-WTA-AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: World Travelers Association, Inc.	Approved-Closed	04/22/2008
Comments:		
Attachments: WTA Articles of Inc. 001.pdf WTA By Laws.pdf mw benefit book0607-final.pdf		

Dallas

Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Steven D. Bryson, F.S.A.
Michael A. Mayberry, F.S.A.
Gregory S. Wilson, F.C.A.S.
David M. Dillon, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Robert E. Gove, A.S.A.
Alexis M. Bash, A.S.A.
Sarah A. Hoover, A.S.A.
Wes R. Campbell, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

**Kansas City**

Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
David L. Batchelder, A.S.A.
Leon L. Langlitz, F.S.A.
Gary R. McElwain, FLMI
Christopher H. Davis, F.S.A.
Thomas L. Handley, F.S.A.
Anthony G. Proulx, F.S.A.
Karen E. Elsom, F.S.A.

London

Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

April 17, 2008

Ms. Rosalind D. Minor
Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Standard Life and Accident Insurance Company NAIC # 86355
World Travelers of America, Inc.
Forms POL-DENT (10/05) AR Group Dental Master Policy, et al

Dear Commissioner:

The above-referenced forms were approved by your Department on May 25, 2006. These forms were approved for use with employer and association groups. The association group approved at that time was the Benefits Association Inc.

Please be advised that at this time, the Company would like to market this plan to a new association group, the World Travelers Association of America, Inc.

I have enclosed for your review and approval the following documents for World Travelers of America, Inc.:

- Articles of Incorporation
- By-Laws
- Guide to Member Benefits

Thank you for your review of this filing. A postage-paid return envelope has been enclosed for your use. If you have any questions or comments, please feel free to call me at (972) 850-3272 or email me at rnaderi@lewisellis.com.

Sincerely,

A handwritten signature in blue ink that reads 'Rebecca Naderi'.

Rebecca Naderi, FLMI, HIA, ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc. – Actuaries & Consultants



Mailing Address: Post Office Box 851857 • Richardson, Texas 75085-1857
2929 N Central Expressway, Suite 200 • Richardson, TX 75080 • 972-850-0850 • FAX: 972-850-0851



WORLD TRAVELERS OF AMERICA, INC.

ARTICLES OF INCORPORATION

FIRST: I, JOHN N. BURDETTE, whose post office address is 22 West Second Street, Frederick, Maryland 21701, being at least eighteen (18) years of age, hereby form a corporation under and by virtue of the General Laws of the State of Maryland.

SECOND: The name of the Corporation (which is hereafter referred to as the "Corporation") is WORLD TRAVELERS OF AMERICA, INC.

THIRD: The purposes for which the Corporation is formed are:

(1) To provide international and domestic travelers information, products, and services that are designed to make travel more enlightening, safer, enjoyable, economical, and hassle-free, including but not limited to newsletters and pamphlets with travel news, tips, and safety information, travel services for members in the nature of arranging discount rates and prices, financial services for members in the nature of arranging credit cards and other financial products, and insurance services for members in the nature of providing or arranging for insurance coverage; to provide association services, namely promoting the interests of travelers and to provide services and membership benefits that will serve the needs of the corporation member, and to engage in any other lawful purpose and business; and

(2) To do anything permitted by Section 2-103 of the Corporations and Associations Article of the Annotated Code of Maryland, as amended from time to time.

FOURTH: The post office address of the principal office of the Corporation in this State is 22 West Second Street, Frederick, Maryland 21701. The name and post office address of the Resident Agent of the Corporation in this State is John N. Burdette, 22 West Second Street, Frederick, Maryland 21701. Said Resident Agent is an individual actually residing in this State.

FIFTH: The total number of shares of capital stock which the Corporation has authority to issue is five thousand (5,000) shares of common stock, without par value.

SIXTH: The number of Directors of the Corporation shall be three (3), which number may be increased or decreased pursuant to the By-Laws of the Corporation, but shall never be less than three (3), provided that:

(1) If there is no stock outstanding, the number of Directors may be less than three (3) but not less than one (1); and

(2) If there is stock outstanding and so long as there are less than three (3) Stockholders, the number of Directors may be less than three (3) but not less than the number of Stockholders.

The names of the Directors who shall act until the first annual meeting or until their successors are duly elected and qualify are:

William P. Condon
Jayne C. Condon
Amy J. Bednarcik

SEVENTH: The following provisions are hereby adopted for the purpose of defining, limiting and regulating the powers of the Corporation and of the Directors and Stockholders.

(1) The Board of Directors of the Corporation is hereby empowered to authorize the issuance from time to time of shares of its stock of any class, whether now or hereafter authorized, or securities convertible into shares of its stock of any class or classes, whether now or hereafter authorized.

(2) The Board of Directors of the Corporation may classify or reclassify any unissued stock by setting or changing in any one or more respects, from time to time before issuance of such stock, the preferences, conversion or other rights, voting powers, restrictions, limitations as to dividends, qualifications, and terms or conditions of redemption of such stock.

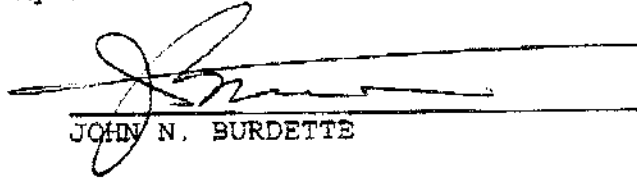
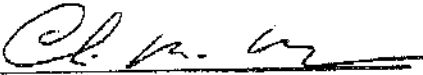
(3) The Corporation reserves the right to amend its Charter so that such amendment may alter the contract rights, as expressly set forth in the Charter, of any outstanding stock, and any objecting Stockholder whose rights may or shall be thereby substantially adversely affected shall not be entitled to demand and receive payment of the face value of his stock.

The enumeration and definition of a particular power of the Board of Directors included in the foregoing shall in no way be limited or restricted by reference to or inference from the terms of any other clause of this or any other article of the Charter of the Corporation, or construed as or deemed by inference or otherwise in any manner to exclude or limit any powers conferred upon the Board of Directors under the Maryland General Corporation Law now or hereafter in force.

EIGHTH: Except as may otherwise be provided by the Board of Directors, no holder of any shares of the capital stock of the Corporation shall have any pre-emptive right to purchase, subscribe for, or otherwise acquire any shares of stock of the Corporation of any class now or hereafter authorized, or any securities exchangeable for or convertible into such shares, or any warrants or other instruments evidencing rights or options to subscribe for, purchase or otherwise acquire such shares.

NINTH: No Director or Officer of the Corporation shall be liable to the Corporation or to its Stockholders for money damages except (1) to the extent that it is proved that such Director or Officer actually received an improper benefit or profit in money, property or services, for the amount of the benefit or profit in money, property or services actually received, or (2) to the extent that a judgment or other final adjudication adverse to such Director or Officer is entered in a proceeding based on a finding in the proceeding that such Director's or Officer's action, or failure to act, was (a) the result of active and deliberate dishonesty, or (b) intentionally wrongful, willful or malicious and, in each such case, was material to the cause of action adjudicated in the proceeding.

IN WITNESS WHEREOF, I have signed these Articles of Incorporation this 5th day of March, 1998, and acknowledge the same to be my act.


JOHN N. BURDETTE

WORLD TRAVELERS OF AMERICA, INC.

BY-LAWS

ARTICLE 1

Stockholders

SECTION 1. Annual Meeting. The annual meeting of the Stockholders of the Corporation shall be held on a day duly designated by the Stockholders in March, if not a legal holiday, and if a legal holiday, then the next succeeding day not a legal holiday, for the transaction of such corporate business as may come before the meeting.

SECTION 2. Special Meeting. Special meetings of the Stockholders may be called at any time for any purpose or purposes by the President, by a Vice-President, or by a majority of the Stockholders, and shall be called forthwith by the President, by a Vice-President, or the Secretary upon the request in writing of the holders of a majority of all the shares outstanding and entitled to vote on the business to be transacted at such meeting. Such request shall state the purpose or purposes of the meeting.

Business transacted at all special meetings of Stockholders shall be confined to the purpose or purposes stated in the notice of the meeting.

SECTION 3. Place of Holding Meetings. All meetings of Stockholders may be held at the principal office of the Corporation or elsewhere in the United States as designated by the Stockholders.

SECTION 4. Notice of Meetings. Written notice of each meeting of the Stockholders shall be mailed, postage prepaid by the Secretary, to each Stockholder of record entitled to vote thereat at his post office address, as it appears upon the books of the Corporation, at least ten (10) days before the meeting. Each such notice shall state the place, day, and hour at which the meeting is to be held and, in the case of any special meeting, shall state briefly the purpose or purposes thereof.

SECTION 5. Quorum. The presence in person or by proxy of the holders of record of a majority of the shares of the capital stock of the Corporation issued and outstanding and entitled to vote thereat shall constitute a quorum at all meetings of the Stockholders, except as otherwise provided by law, by the Articles of Incorporation or by these By-Laws. If less than a quorum shall be in attendance at the time for which the meeting shall have been called, the meeting may be adjourned from time to time by a majority vote of the Stockholders present or represented, without any notice other than by announcement at the meeting, until a quorum shall attend. At any adjourned meeting at which a quorum

shall attend, any business may be transacted which might have been transacted if the meeting had been held as originally called.

SECTION 6. Conduct of Meetings. Meetings of Stockholders shall be presided over by the President of the Corporation or if he is not present, by a Vice-President, or, if none of said officers is present, by a chairman to be elected at the meeting. The Secretary of the Corporation, or if he is not present, any Assistant Secretary shall act as Secretary of such meetings; in the absence of the Secretary and any Assistant Secretary, the presiding Officer may appoint a person to act as Secretary of the meeting.

SECTION 7. Voting. At all meetings of Stockholders, every Stockholder entitled to vote thereat shall have one (1) vote for each share of stock standing in his name on the books of the Corporation on the date for the determination of Stockholders entitled to vote at such meeting. Such vote may be either in person or by proxy appointed by an instrument in writing, subscribed by such Stockholder or his duly authorized attorney, bearing a date not more than three (3) months prior to said meeting, unless said instrument provides for a longer period. Such proxy shall be dated, but need not be sealed, witnessed or acknowledged. All elections shall be had and all questions shall be decided by a majority of the votes cast at a duly constituted meeting, except as otherwise provided by law, in the Articles of Incorporation or by these By-Laws.

If the Chairman of the meeting shall so determine, a vote by ballot may be taken upon any election or matter, and the vote shall be so taken upon the request of the holders of ten (10%) percent of stock entitled to vote on such election or matter. In either of such events, the proxies and ballots shall be received and be taken in charge and all questions touching the qualification of voters and the validity of proxies and the acceptance or rejection of votes, shall be decided by the tellers. Such tellers shall be appointed by the chairman of said meeting.

ARTICLE II

Board of Directors

SECTION 1. General Powers. The property and business of the Corporation shall be managed under the direction of the Board of Directors of the Corporation.

SECTION 2. Number and Term of Office. The number of directors shall be three (3) or such other number as may be designated from time to time by resolution of a majority of the entire Board of Directors. Directors need not be stockholders. The Directors shall be elected each year at the annual meeting of Stockholders, except as hereinafter provided, and each Director shall serve until his successor shall be elected and shall qualify.

SECTION 3. Filling of Vacancies. In the case of any vacancy in the Board of Directors through death, resignation, disqualification, removal or other cause, the remaining Directors, by affirmative vote of the majority thereof, may elect a successor to hold office for the unexpired portion of the term of the Director whose place shall be vacant, and until the election of his successor, or until he shall be removed, prior thereto, by an affirmative vote of the holders of a majority of the stock.

Similarly and in the event of the number of Directors being increased as provided in these By-Laws, the additional Directors so provided for shall be elected by a majority of the entire Board of Directors already in office, and shall hold office until the next annual meeting of Stockholders and thereafter until his or their successors shall be elected.

Any Director may be removed from office with or without cause by the affirmative vote of the holders of the majority of the stock issued and outstanding and entitled to vote at any special meeting of Stockholders regularly called for the purposes.

SECTION 4. Place of Meeting. The Board of Directors may hold their meetings and have one or more offices, and keep the books of the Corporation, either within or outside the State of Maryland, at such place or places as they may from time to time determine by resolution or by written consent of all the Directors. The Board of Directors may hold their meetings by conference telephone or other similar electronic communications equipment in accordance with the provisions of the Maryland Corporation Law.

SECTION 5. Regular Meetings. Regular meetings of the Board of Directors may be held without notice at such time and place as shall from time to time be determined by resolution of the Board, provided that notice of every resolution of the Board fixing or changing the time or place for the holding of regular meetings of the Board shall be mailed to each Director at least three (3) days before the first meeting held pursuant thereto. The annual meeting of the Board of Directors shall be held immediately following the annual Stockholders' meeting at which a Board of Directors is elected. Any business may be transacted at any regular meeting of the Board.

SECTION 6. Special Meetings. Special meetings of the Board of Directors shall be held whenever called by direction of the Chairman of the Board or the President and must be called by the Chairman of the Board, the President or the Secretary upon written request of a majority of the Board of Directors. The Secretary shall give notice of each special meeting of the Board of Directors, by mailing the same at least three (3) days prior to the meeting or by telegraphing the same at least two (2) days before the meeting, to each Director; but such notice may be waived by any Director. Unless otherwise indicated in the notice thereof, any and

all business may be transacted at any special meeting. At any meeting at which every Director shall be present, even though without notice, any business may be transacted and any Director may in writing waive notice of the time, place and objectives of any special meeting.

SECTION 7. Quorum. A majority of the whole number of Directors shall constitute a quorum for the transaction of business at all meetings of the Board of Directors, but, if at any meeting less than a quorum shall be present, a majority of those present may adjourn the meeting from time to time, and the act of a majority of the Directors present at any meeting at which there is a quorum shall be the act of the Board of Directors, except as may be otherwise specifically provided by law or by the Articles of Incorporation or by these By-Laws.

SECTION 8. Compensation of Directors. Directors shall not receive any stated salary for their services as such, but each Director shall be entitled to receive from the Corporation reimbursement of the expenses incurred by him in attending any regular or special meeting of the Board, and, by resolution of the Board of Directors, a fixed sum may also be allowed for attendance at each regular or special meeting of the Board and such reimbursement and compensation shall be payable whether or not a meeting is adjourned because of the absence of a quorum. Nothing herein contained shall be construed to preclude any Director from serving the Corporation in any other capacity and receiving compensation therefor.

SECTION 9. Committees. The Board of Directors may, by resolution passed by a majority of the whole Board, designate one or more committees, each committee to consist of two or more of the Directors of the Corporation, which, to the extent provided in the resolution, shall have and may exercise the powers of the Board of Directors, and may authorize the seal of the Corporation to be affixed to all papers which may require it. Such committee or committees shall have such names as may be determined from time to time by resolution adopted by the Board of Directors.

ARTICLE III

Officers

SECTION 1. Election, Tenure and Compensation. The Officers of the Corporation shall be a President, a Secretary, and a Treasurer, and also such other Officers including a Chairman of the Board and/or one or more Vice Presidents and/or one or more assistants to the foregoing Officers as the Board of Directors from time to time may consider necessary for the proper conduct of the business of the Corporation. The Officers shall be elected annually by the Board of Directors at its first meeting following the annual meeting of the Stockholders except where a longer term

is expressly provided in an employment contract duly authorized and approved by the Board of Directors. The President and Chairman of the Board shall be Directors and the other Officers may, but need not be, Directors. Any two or more of the above offices, except those of President and Vice President, may be held by the same person, but no Officer shall execute, acknowledge or verify any instrument in more than one capacity if such instrument is required by Law or by these By-Laws to be executed, acknowledged or verified by any two or more Officers. The compensation or salary paid all Officers of the Corporation shall be fixed by resolutions adopted by the Board of Directors.

In the event that any office other than an office required by Law, shall not be filled by the Board of Directors, or, once filled, subsequently becomes vacant, then such office and all references thereto in these By-Laws shall be deemed inoperative unless and until such office is filled in accordance with the provisions of these By-Laws.

Except where otherwise expressly provided in a contract duly authorized by the Board of Directors, all Officers and agents of the Corporation shall be subject to removal at any time by the affirmative vote of a majority of the whole Board of Directors, and all Officers, agents, and employees shall hold office at the discretion of the Board of Directors or of the Officers appointing them.

SECTION 2. Powers and Duties of the Chairman of the Board. The Chairman of the Board shall preside at all meetings of the Board of Directors unless the Board of Directors shall by a majority vote of a quorum thereof elect a chairman other than the Chairman of the Board to preside at meetings of the Board of Directors. He may sign and execute all authorized bonds, contracts or other obligations in the name of the Corporation; and he shall be ex-officio a member of all standing committee.

SECTION 3. Powers and Duties of the President. The President shall be the Chief Executive Officer of the Corporation and shall have general charge and control of all its business affairs and properties. He shall preside at all meetings of the Stockholders.

The President may sign and execute all authorized bonds, contracts or other obligations in the name of the Corporation. He shall have the general powers and duties of supervision and management usually vested in the office of President of the Corporation. The President shall be ex-officio a member of all the standing committees. He shall do and perform such other duties as may, from time to time, be assigned to him by the Board of Directors.

In the event that the Board of Directors does not take affirmative action to fill the office of Chairman of the Board, the President shall assume and perform all powers and duties given to the Chairman of the Board by these By-Laws.

SECTION 4. Powers and Duties of the Vice President. The Board of Directors shall appoint a Vice President, may appoint more than one Vice President and may designate an Executive Vice President. Any Vice President (unless otherwise provided by resolution of the Board of Directors) may sign and execute all authorized bonds, contracts, or other obligations in the name of the Corporation. Each Vice President shall have such other powers and shall perform such other duties as may be assigned to him by the Board of Directors or by the President. In case of the absence or disability of the President, the duties of that office shall be performed by any Vice President, and the taking of any action by any such Vice President in place of the President shall be conclusive evidence of the absence or disability of the President.

SECTION 5. Secretary. The Secretary shall give, or cause to be given, notice of all meetings of Stockholders and Directors and all other notices required by law or by these By-Laws, and in case of his absence or refusal or neglect to do so, any such notice may be given by any person thereunto directed by the President, or by the Directors or Stockholders upon whose request the meeting is called as provided in these By-Laws. The Secretary shall record all the proceedings of the meetings of the Stockholders and of the Directors in books provided for that purpose, and he shall perform such other duties as may be assigned to him by the Directors or the President. He shall have custody of the seal of the Corporation and shall affix the same to all instruments requiring it, when authorized by the Board of Directors or the President, and attest the same. In general, the Secretary shall perform all the duties generally incident to the office of Secretary, subject to the control of the Board of Directors and the President.

SECTION 6. Treasurer. The Treasurer shall have custody of all the funds and securities of the Corporation, and he shall keep full and accurate account of receipts and disbursements in books belonging to the Corporation. He shall deposit all moneys and other valuables in the name and to the credit of the Corporation in such depository or depositories as may be designated by the Board of Directors.

The Treasurer shall disburse the funds of the Corporation as may be ordered by the Board of Directors, taking proper vouchers for such disbursements. He shall render to the President and the Board of Directors, whenever either of them so requests, an account of all his transactions as Treasurer and of the financial condition of the Corporation.

The Treasurer shall give the Corporation a bond, if required by the Board of Directors, in a sum, and with one or more sureties, satisfactory to the Board of Directors, for the faithful performance of the duties of his office and for the restoration to the Corporation in case of his death, resignation, retirement or removal from office of all books, papers, vouchers, moneys, and other properties of whatever kind in his possession or under his control belonging to the Corporation.

The Treasurer shall perform all the duties generally incident to the office of the Treasurer, subject to the control of the Board of Directors and the President.

SECTION 7. Assistant Secretary. The Board of Directors may appoint an Assistant Secretary or more than one Assistant Secretary. Each Assistant Secretary shall (except as otherwise provided by resolution of the Board of Directors) have power to perform all duties of the Secretary in the absence or disability of the Secretary and shall have such other powers and shall perform such other duties as may be assigned to him by the Board of Directors or the President. In case of the absence or disability of the Secretary, the duties of the office shall be performed by any Assistant Secretary, and the taking of any action by any such Assistant Secretary in place of the Secretary shall be conclusive evidence of the absence or disability of the Secretary.

SECTION 8. Assistant Treasurer. The Board of Directors may appoint an Assistant Treasurer or more than one Assistant Treasurer. Each Assistant Treasurer shall (except as otherwise provided by resolution of the Board of Directors) have power to perform all duties of the Treasurer in the absence or disability of the Treasurer and shall have such other powers and shall perform such other duties as may be assigned to him by the Board of Directors or the President. In case of the absence or disability of the Treasurer, and the taking of any action by any such Assistant Treasurer in place of the Treasurer shall be conclusive evidence of the absence or disability of the Treasurer.

ARTICLE IV

Capital Stock

SECTION 1. Issuance of Certificates of Stock. The certificates of shares of the stock of the Corporation shall be of such form not inconsistent with the Articles of Incorporation, or its amendments, as shall be approved by the Board of Directors. All certificates shall be signed by the President or by the Vice President and countersigned by the Secretary or by an Assistant Secretary. All certificates for each class of stock shall be consecutively numbered. The name of the person owning the shares issued and the address of the holder, shall be entered in the Corporation's books. All certificates surrendered to the

Corporation for transfer shall be cancelled and no new certificates representing the same number of shares shall be issued until the former certificate or certificates for the same number of shares shall have been so surrendered, and cancelled, unless a certificate of stock be lost or destroyed, in which event another may be issued in its stead upon proof of such loss or destruction and unless waived by the President, the giving of a satisfactory bond of indemnity not exceeding an amount double the value of the stock. Both such proof and such bond shall be in a form approved by the general counsel of the Corporation and by the Transfer Agent of the Corporation and by the Registrar of the stock.

SECTION 2. Transfer of Shares. Shares of the capital stock of the Corporation shall be transferred on the books of the Corporation only by the holder thereof in person or by his attorney upon surrender and cancellation of certificates for a like number of shares as hereinbefore provided.

SECTION 3. Registered Stockholders. The Corporation shall be entitled to treat the holder of record of any share or shares of stock as the holder in fact thereof and accordingly shall not be bound to recognize any equitable or other claim to or interest in such share in the name of any other person, whether or not it shall have express or other notice thereof, save as expressly provided by the Laws of Maryland.

SECTION 4. Closing Transfer Books. The Board of Directors may fix the time, not exceeding ten (10) days preceding the date of any meeting of Stockholders or any dividend payment date or any date for the allotment of rights, during which time the books of the Corporation shall be closed against transfer of stock, or, in lieu thereof, the Directors may fix a date not exceeding ten (10) days preceding the date of any meeting of Stockholders or any dividend payment date or any date for the allotment of rights, as a record date for the determination of the Stockholders entitled to notice of and to vote at such meeting or to receive such dividends or rights as the case may be; and only Stockholders of record on such date shall be entitled to notice of and to vote at such meeting or to receive such dividends or rights as the case may be.

ARTICLE V

Corporate Seal

SECTION 1. Seal. In the event that the President shall direct the Secretary to obtain a corporate seal, the corporate seal shall be circular in form and shall have inscribed thereon the name of the Corporation, the year of its organization and the word "Maryland". Duplicate copies of the corporate seal may be provided for use in the different offices of the Corporation but each copy thereof shall be in the custody of the Secretary of the Corporation

or of an Assistant Secretary of the Corporation nominated by the Secretary.

ARTICLE VI

Bank Accounts and Loans

SECTION 1. Bank Accounts. Such Officers or agents of the Corporation as from time to time shall be designated by the Board of Directors shall have authority to deposit any funds of the Corporation in such banks or trust companies as shall from time to time be designated by the Board of Directors and such Officers or agents as from time to time shall be authorized by the Board of Directors may withdraw any or all of the funds of the Corporation so deposited in any such bank or trust company, upon checks, drafts or other instruments or orders for the payment of money, drawn against the account or in the name or on behalf of this Corporation, and made or signed by such Officers or agents; and each bank or trust company with which funds of the Corporation are so deposited is authorized to accept, honor, cash and pay, without limit as to amount, all checks, drafts or other instruments or orders for the payment of money, when drawn, made or signed by Officers or agents so designated by the Board of Directors until written notice of the revocation of the authority of such Officers or agents by the Board of Directors shall have been received by such bank or trust company. There shall from time to time be certified to the banks or trust companies in which funds of the Corporation are deposited, the signature of the Officers or agents of the Corporation so authorized to draw against the same. In the event that the Board of Directors shall fail to designate the persons by whom checks, drafts and other instruments or orders for the payment of money shall be signed, as hereinabove provided in this Section, all of such checks, drafts and other instruments or orders for the payment of money shall be signed by the President or a Vice President and countersigned by the Secretary or Treasurer or an Assistant Secretary or an Assistant Treasurer of the Corporation.

SECTION 2. Loans. Such Officers or agents of this Corporation as from time to time shall be designated by the Board of Directors shall have authority to effect loans, advances or other forms of credit at any time or times for the Corporation from such banks, trust companies, institutions, corporations, firms or persons as the Board of Directors, shall from time to time designate, and as security for the repayment of such loans, advances, or other forms of credit to assign, transfer, endorse and deliver, either originally or in addition or substitution, any or all stocks, bonds, certificates of such rights or interests, deposits, accounts, documents covering merchandise, bills and accounts receivable and other commercial paper and evidence of debt at any time held by the Corporation; and for such loans, advances or other forms of credit to make, execute and deliver one or more

notes, acceptances or written obligations of the Corporation on such terms, and with such provisions as to the security or sale or disposition thereof as such Officers or agents shall deem proper; and also to sell to, discount or rediscount with, such banks, trust companies, institutions, corporations, firms or persons any and all commercial paper, bills receivable, acceptances and other instruments and evidences of debt at any time held by the Corporation, and to that end to endorse, transfer and deliver the same. There shall from time to time be certified to each bank, trust company, institution, corporation, firm or person so designated the signatures of the Officers or Agents so authorized; and each such bank, trust company, institution, corporation, firm or person is authorized to reply upon such certification until written notice of the revocation by the Board of Directors of the authority of such Officers or Agents shall be delivered to such bank, trust company, institution, corporation, firm or person.

ARTICLE VII

Reimbursements

Any payments made to an Officer or other employee of the Corporation, such as salary, commission, interest or rent, or entertainment expense incurred to him, which shall be disallowed in whole or in part as a deductible expense by the Internal Revenue Service, shall be reimbursed by such Officer or other employee of the Corporation to the full extent of such disallowance. It shall be the duty of the Directors, as a Board, to enforce payment of each such amount disallowed. In lieu of payment by the Officer or other employee, subject to the determination of the Directors, proportionate amounts may be withheld from his future compensation payments until the amount owed to the Corporation has been recovered.

ARTICLE VIII

Miscellaneous Provisions

SECTION 1. Fiscal Year. The fiscal year of the Corporation shall end on the last day of December.

SECTION 2. Notices. Whenever, under the provisions of these By-Laws, notice is required to be given to any Director, Officer or Stockholder, it shall not be construed to mean personal notice, but such notice shall be given in writing, by mail, by depositing the same in a post office or letter box, in a postpaid sealed wrapper, addressed to each Stockholder, Officer or Director at such address as appears on the books of the Corporation, or in default of any other address, to such Director, Officer or Stockholder, at the general post office in the City of ^, Maryland, and such notice shall be deemed to be given at the time the same

shall be thus mailed. Any Stockholder, Director or Officer may waive any notice required to be given under these By-Laws.

ARTICLE IX

Amendments

SECTION 1. Amendment of By-Laws. The Board of Directors shall have the power and authority to amend, alter or repeal these By-Laws or any provision thereof, and may from time to time make additional By-Laws.

ARTICLE X

Indemnification

SECTION 1. Definitions. As used in this Article X, any word or words that are defined in Section 2-418 of the Corporations and Associations Article of the Annotated Code of Maryland, as amended from time to time, (the "Indemnification Section") shall have the same meaning as provided in the Indemnification Section.

SECTION 2. Indemnification of Directors and Officers. The Corporation shall indemnify and advance expenses to a Director or Officer of the Corporation in connection with a proceeding to the fullest extent permitted by and in accordance with the Indemnification Section.

SECTION 3. Indemnification of Employees and Agents. With respect to an employee or agent, other than a Director or Officer, of the Corporation, the Corporation may, as determined by the Board of Directors of the Corporation, indemnify and advance expenses to such employee or agent in connection with a proceeding to the extent permitted by and in accordance with the indemnification Section.

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We will primarily communicate with you via e-mail and through our website, *WTA Online*®. If you haven't already, please be sure to set up your member log in account at www.worldtravelers.org. Just click "Member Log In" on the homepage and follow the prompts from there. It's quick and easy and will give you access to the Member's Only section of *WTA Online* where you'll find your member benefits and discounts.

For those of you who are members because you carry WTA's MasterCard® credit card, it is important for you to know that while you will receive WTA's newsletter, *The WTA Wise Traveler*®, in your credit card statements (if you receive a statement for that particular month), you should also set up your member log in account at www.worldtravelers.org. That way, you will receive all of WTA's communications and will have access to all of your member benefits and discounts.

Thank you for your support of WTA. With it we are working to make travel safer, more affordable and hassle-free.

Wishing you safe and fun travels,



William P. Condon
President

MEMBER SERVICES CONTACT INFORMATION

World Travelers of America Association

Phone: 508-432-8846

E-mail: admin@worldtravelers.org

Website: www.worldtravelers.org

Office Hours: Monday-Friday 8:30 a.m. - 5:00 p.m. ET

MEMBER BENEFITS LISTING

All member benefits may be accessed at www.worldtravelers.org. Certain benefits also offer access via a toll-free phone number. Refer to each benefit explanation for additional details and contact information.

TRAVEL INFORMATION

The WTA Wise Traveler® Newsletter

Travel Talk® E-newsletter

WTA Travel Destination Information

WTA Travel Safety Advisory Information

WTA Travel Health Program

WTA Travel Tips

INSURANCE & FINANCE SERVICES

WTA Travel Insurance Program

WTA MasterCard® Credit Card

WTA RV Finance Program

MEMBER DISCOUNTS

WTA Online® Travel Booking Service

WTA Lodging Discount Program

WTA Auto Rental Discount Program

WTA Theme Park & Zoo Discounts

WTA CityPass® Discounts

WTA Ski Resort Discounts

WTA Movie Ticket Discounts

WTA Magazine Discount Program

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WTA Online® provides instant access to almost all WTA member benefits, products, services and discounts, plus many other resources tailored to travel interests. Access to your member benefits is in a special Members Only section of the website. New member benefits are often announced first on the website, so be sure to visit often.

The WTA Wise Traveler® Newsletter

The WTA Wise Traveler® newsletter is a quick-to read newsletter published six times a year that provides destination information, travel news, and travel tips along with the latest updates on member benefits. This information will cover both U.S. and foreign travel. WTA members who have a WTA MasterCard® credit card will receive *The WTA Wise Traveler* in their credit card statements. All other members will receive the newsletter via e-mail.

Travel Talk® E-newsletter

Travel Talk® is delivered via e-mail six times a year as part of WTA's mission to make travel safer, more affordable and hassle-free. Each issue focuses on a relevant travel topic. All WTA members who have provided their email address automatically receive *Travel Talk*.

WTA Travel Destination Information

WTA's travel destination information offers members access to a number of first-hand accounts of destinations around the U.S. and the world. The information encompasses the best time of year to go, what to do and see, costs, inside tips on places to eat and stay, and other truly valuable information. New destinations are constantly added, so be sure to visit often. Also included is tourism and U.S. State Department information.

WTA Travel Safety Advisory Information

The WTA Travel Safety Advisory Program provides access to safety information and tips, including travel alerts, to assist WTA members to be safe travelers on key topics such as hotel security, women traveling alone, advanced planning for a safe trip abroad, and personal security while traveling in the U.S.

WTA Travel Health Program

The WTA Travel Health Program offers a variety of resources to help WTA members travel safely and to stay healthy while traveling. WTA's partner, Passport Health®, offers convenient, comprehensive, and affordable briefing services on the health and security of foreign destinations. They also provide vaccinations, security and medical safety advice. Present your WTA MasterCard® credit card to a Passport Health representative and receive a free gift. For more details and to locate the Passport Health office nearest you, go to www.worldtravelers.org/travelhealth.asp.

WTA Travel Tips

WTA supplies a myriad of travel tips to help ease its members' travels on subjects such as family travel, air travel, travel security, lodging, currency, cultural dos and don'ts, luggage & packing, accommodations and many more.

WTA Travel Insurance Program

WTA's Travel Insurance Program offers a suite of travel insurance products designed to ease the hassles of travel – whether in the U.S. or abroad.

There are hundreds of circumstances that could cause you to cancel your trip, return home early or force you to seek emergency medical treatment while traveling. These expenses aren't typically covered by your own health or homeowner's insurance or credit card. Get a free instant quote and purchase coverage online.

WTA RV Finance Program

WTA members can finance their new or used RVs online or by phone at 866-789-4511. Competitive rates are available for both financing and refinancing.

WTA Online® Travel Booking Service

Members can check rates and book their travel online at www.worldtravelers.org. Deeply discounted rates are available on hotels, cruises, vacation condo rentals, and rental cars. Book air, too. You have a choice of booking with major airlines, hotels, cruise lines, and auto rental agencies across the country and the world. Online customer care is available at reply@travelnow.com 24/7 (including holidays). For help with existing reservations or to book a hotel room, you may also call 800-916-3403.

WTA Lodging Discount Program

WTA members can take advantage of special lodging discounts of up to 15% at select hotel properties across the U.S. and abroad.

This special discount is available at: Days Inn® – 800-268-2195; Howard Johnson® – 800-769-0939; Knights Inn® – 800-682-1071; Ramada® – 800-462-8035; Travelodge® – 800-545-5545; and Wingate Inn® – 877-202-8814. Be sure to use discount #60093.

WTA Auto Rental Discount Program

WTA members save up to 25% off auto rentals from the following companies: Avis® - 800-331-1212, ID# B853102; Budget® - 800-455-2848, ID# Y194902; Enterprise® - 800-593-0505, ID# 07A1001; and Hertz® - 800-654-2200, ID# 1294401. Plus, every time you rent from Avis, Budget or Hertz, a percentage will be contributed to WTA to help support its mission.

WTA Theme Park and Zoo Discounts

WTA members save up to 30% on admission to over 60 major theme parks, zoos and aquariums across the country like Six Flags®, Universal Studios®, Busch Gardens®, Sea World®, HersheyPark®, the San Diego Zoo® and the Los Angeles Zoo®. The discount coupons are mailed to you.

WTA CityPass® Discounts

Visit attractions in some of North America's most popular cities for one low price. Savings are almost 50% off individual admission prices. Currently participating cities are Boston, Chicago, Hollywood, New York, Philadelphia, San Francisco, Seattle, Southern California, and Toronto.

WTA Ski Resort Discounts

Save up to \$26.50 per lift ticket at ski resorts from Maine to California. Shipping and handling fees apply.

WTA Movie Discounts

Save up to \$3 on each movie ticket at most of the national chains. Discount tickets to many regional theatres are also available. Shipping and handling fees apply.

WTA Magazine Discount Program

WTA members receive deep discounts of up to 50% off travel magazines such as *Caribbean Travel and Life*, *Cruise Travel, Vacations*, and many of your favorite non-travel publications like *Reader's Digest*, *Car & Driver*, *Time*, *Golf Digest*, and *Ladies Home Journal*. Hundreds of other titles are available. Call 800-603-5602 to order.

General Provisions of the WTA Member Benefits

This *Guide to Member Benefits* is a helpful and important document, and all information in it is subject to the terms and conditions of WTA's contractual documents.

Access to the benefits becomes effective when you become a member of WTA. WTA reserves the right to change or terminate the benefits without notice. The benefits provided to you via your WTA Membership may not be assigned.

6/2007MW

Guide To Member Benefits



*Working to make Travel Safer,
More Affordable and Hassle-Free!*

World Travelers of America

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508-432-8846

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SERFF Tracking Number: AMFT-126726824 State: Arkansas

Filing Company: Monitor Life Insurance Company of New York State Tracking Number: 46430

Company Tracking Number: ML-POL-DENT (10/05) AR

TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental

Product Name: Group Dental

Project Name/Number: ML-POL-DENT (10/05)/ML-POL-DENT (10/05)

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/20/2010	Form	Group Dental Master Policy	08/12/2010	ML-POL-DENT 1005.pdf (Superceded)
07/20/2010	Form	Group Dental Certificate for Association Members	08/12/2010	ML-MCERT-DENT 1005.pdf (Superceded)
07/20/2010	Form	Group Dental Certificate for Employees	08/12/2010	ML-ECERT-DENT 1005.pdf (Superceded)

Monitor Life Insurance Company of New York

70 Genesee Street
Utica, New York 13502
Telephone (800)422-6200

(Herein called the Company)

Acknowledgment of Application for Group Dental Insurance Contract

Dental Care Plan

[Doe & Doe, LTD], has applied for a Group Dental Insurance Contract with **Monitor Life Insurance Company of New York** ("Monitor"). A copy of the application is attached to this contract. The following terms will apply:

- I. Applicant shall pay Monitor the monthly Premium stated in the Contract.
- II. Monitor has accepted the Application submitted by the Applicant and when Applicant pays the first month's Premium, the term of the Contract shall begin at 12:01 a.m., on the Effective Date listed in Appendix A. The term of the Contract shall end as stated in the Contract at the end of the Contract Term at 12:00 midnight Standard Time.
- III. Applicant shall give each Primary Enrollee a certificate furnished by Monitor. Applicant shall also distribute to its Enrollees any notice from Monitor which affects their rights under the Contract.

**Notice: The premium under this contract is payable to
Monitor Life Insurance Company of New York
Attention: Morgan White Administrators
P. O. Box 16708
Jackson, Mississippi 39236**

The premium under this contract may be increased upon renewal after the end of the initial or any subsequent contract terms.

Monitor Life Insurance Company of New York ("Monitor") accepts the Application of "Applicant." A copy is attached and made a part of this Contract. So long as Applicant pays the Premiums stated in Article 3, Monitor agrees to provide the Benefits described in Article 4. Benefits will start at 12:01 a.m. Standard Time on the Effective Date. This Contract will continue from year to year until terminated, as stated in Article 8.

This Contract is issued and delivered in the **State of [New York]** and is governed by its laws.

IN WITNESS WHEREOF Monitor Life Insurance Company of New York has caused this Policy/Certificate to be executed and to take effect on the Effective Date.

Secretary

President

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Article 1 Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

- 1.01 **“Applicant”** – the employer, association or other organization or group contracting to obtain Benefits.
- 1.02 **“Approved Amount”** – the total fee chargeable for a Single Procedure.
- 1.03 **“Attending Dentist’s Statement”** – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.
- 1.04 **“Benefits”** – the amounts that Monitor will pay for dental services under Article 4.
- 1.05 **“Calendar Year”** – the 12 months of the year from January 1 through December 31.
- 1.06 **“Contract”** – this agreement between Monitor and Applicant, including the Application and the attachments listed in Article 9.
- 1.07 **“Contract Allowance”** – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist’s submitted fee, and the Scheduled Maximum, if any, and the Dentist’s fee filed with Monitor in the Participating Dentist Agreement, if any, or the UCR.
- 1.08 **“Contract Term”** – the period during which the Contract is in effect, as shown in Appendix A.
- 1.09 **“Contract Year”** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and maximums will be determined using this 12 month period rather than on a calendar year basis.
- 1.10 **“Dentist”** – a person licensed to practice dentistry when and where services are performed.
- 1.11 **“Dependent Enrollee”** – an Eligible Dependent enrolled in the plan to receive Benefits.
- 1.12 **“Effective Date”** – the date the program starts, as shown in Appendix A.
- 1.13 **“Eligible Dependent”** – a dependent of an Eligible Person eligible for Benefits under Article 2.

- 1.14 **“Eligible Person”** – a person as listed in Appendix A, designated by the Applicant as eligible for Benefits under Article 2.
- 1.15 **“Enrollee”** – an Eligible Person (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.
- 1.16 **“Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist”** – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. A Non-Participating Dentist may charge more than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.
- 1.17 **“Open Enrollment Period”** – the month(s) of the year, as shown in Appendix A, during which Eligible Persons may change coverage for the next Contract Year.
- 1.18 **“Predetermination”** – Monitor shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.
- 1.19 **“Preferred, Network, Contracting, Participating Dentist”** – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. See Non-Participating Dentist.
- 1.20 **“Premiums”** – the amounts payable monthly by the Applicant as required in the Contract.
- 1.21 **“Primary Enrollee”** – an Eligible Person enrolled in the plan to receive Benefits.
- 1.22 **“Procedure Number”** – the number given to a Single Procedure in the Monitor Dental Uniform Procedure Code and Nomenclature attached as Appendix B.
- 1.23 **“Qualifying Family Status Change”** – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.

- 1.24 **“Scheduled Maximum”** – the maximum Contract Allowance for each dental procedure, as shown in Appendix B, if any.
- 1.25 **“Single Procedure”** – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).
- 1.26 **“UCR”** – “usual, customary and reasonable” which have the following meanings:

Usual – A “usual” fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is “customary” when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic areas determined by Monitor to be relevant. Customary fees may be determined on the basis of fees filed with Monitor by Participating Dentist. A Customary fee for a Participating Dentist is that fee which is approved by Monitor in the terms of the Participating Dentist Agreement.

Reasonable – A fee is “reasonable” if it is “usual” and “customary” or if it falls above “usual” and “customary” or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

- 1.27 **“Uniform Procedure Code”** – the Monitor Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.
- 1.28 **“We, Our, or Us”** – Monitor, and will be used without respect to capitalization.
- 1.29 **“You, Your, Yours”** – the Primary Enrollee and will be used without respect to capitalization.

Article 2 Eligibility and Enrollment

- 2.01 **Reporting** Applicant shall furnish to Monitor on or before the Effective Date, and by the first day of every month, a list of all Primary Enrollees. The list must show their Social Security numbers, dates of [hire] and location codes, if any. Monitor shall not pay Benefits for any Enrollee or any dependents if the Enrollee is not on the list of Primary Enrollees. Nor will Monitor pay Benefits for an Enrollee if the Premium has not been paid for the month when the dental services are performed. However, a child shall be covered for 31 days

after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

- 2.02 Applicant shall permit Monitor to audit Applicant's records to check whether the lists of Primary Enrollees are correct and to confirm compliance with Article 3. Monitor shall give Applicant written notice within a reasonable time before the audit date.

2.03 **Eligible Persons** Eligible Persons are:

All present and future permanent [employees of Applicant working full-time the minimum number of hours shown in Appendix A] shall become eligible on the calendar day shown in Appendix A of the month after they have [worked full-time for the minimum number of months shown as the Eligibility Period in Appendix A].

2.04 **Eligible Dependents** Eligible Dependents of an Eligible Person are:

- a) Lawful spouse.
- b) An unmarried child from birth to the 19th birthday, or 25th birthday if a full-time student in an accredited school. "Children" include natural children, stepchildren, adopted children and foster children. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the point of placement in the physical custody of the Eligible Person, as certified by the agency-making placement.
- c) An unmarried child 19 years or older may continue to be eligible as a dependent if the child is not self-supporting because of mental incapacity or physical handicap that began before age 19 and the child is mostly dependent on the Eligible Person for support and maintenance. Proof of these facts must be given to Monitor or Applicant within 31 days if it is requested. Proof shall not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

2.05 **Enrollment of Eligible Persons and Eligible Dependents**

- a) If Applicant pays the entire cost of coverage, all Eligible Persons and Eligible Dependents are Enrollees covered under the plan. Coverage cannot be waived.

- b) If an Eligible Person must contribute any portion of the cost of coverage, Eligible Persons and their Eligible Dependents must enroll to be covered under the plan. Enrollment must be within 30 days after first becoming eligible or during an Open Enrollment Period. Coverage may not be dropped or changed other than during an Open Enrollment Period or because of a Qualifying Family Status Change.
 - c) The Primary Enrollee pays the cost of coverage, by the method elected by the applicant, for Dependent Enrollees until they are no longer dependents or until the Primary Enrollee chooses to drop coverage. Coverage may not be changed or dropped at any time other than during an Open Enrollment Period or because of a Qualifying Family Status Change.
 - d) If both spouses are Eligible Persons, one may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.
 - e) If the Primary Enrollee enrolls any dependent for dependent coverage, all Eligible Dependents must be enrolled as Dependent Enrollees.
- 2.06 If the Applicant is a Primary Enrollee's employer, then except for an employee absent from work due to a leave of absence governed by the "Family Medical Leave Act of 1993" (P.L. 103.3), an Enrollee shall not be covered for any dental services received while a Primary Enrollee is on strike, lay-off or leave of absence. Applicant must inform Monitor of any change in eligibility as required under Section 2.01.

Coverage shall resume on the first day of the month after the Primary Enrollee returns to work. Such Primary Enrollees shall be considered as newly hired employees with respect to the application of deductibles and maximums when they return to work. If an absence exceeds six (6) months, then such Primary Enrollees shall be considered newly hired employees in every respect and must fulfill the eligibility requirements.

- 2.07 A Primary Enrollee loses coverage on the last day of the month of employment or on the day the Contract is terminated. Dependent Enrollees lose coverage along with the Primary Enrollee, or earlier if dependent status is lost.

Article 3 Monthly Premiums

- 3.01 Applicant shall remit the monthly Premium in the amount and manner shown in Appendix A for all Primary Enrollees and Dependent Enrollees to:

Monitor Life Insurance Company of New York
Attention: Membership Services
P. O. Box 16708
Jackson, Mississippi 39236

- 3.02 This Contract shall not be in effect until Monitor receives the first month's Premiums. Subsequent Premiums shall be paid by the first day of each month. For each Premium after the first, a grace period of 30 days from the due date will be allowed for the payment of Premium. The Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, Monitor may terminate the Contract as of the due date in accordance with the notice requirements of Section 8.01.
- 3.03 If this Contract is terminated before the end of a Contract Term, Applicant shall pay additional charges in accordance with Article 8.
- 3.04 Monitor may change the rate of monthly Premium whenever the Contract is amended. Any change in Premium shall not be effective during a Contract Term unless Applicant and Monitor agree in writing, except as provided in 3.06 below.
- 3.05 Premiums are based on the number of covered Primary Enrollees. If the Applicant reports a difference in the number of covered Primary Enrollees, as shown in Appendix A, for three months in a row, Monitor may propose a choice of change in Premiums or Benefits to remedy the increase in cost per person which may result from fewer enrolled Primary Enrollees. Within 30 days, Applicant shall select one of the choices by written notice to Monitor. If Applicant fails to do so, Monitor may select one of the choices by written notice to Applicant. The Contract shall be modified for dental services Predetermined and paid after notice.
- 3.06 If, during the Contract Term, any new or increased tax is imposed on the amounts payable to Monitor under this Contract, the amount stated in Section 3.01 shall be increased by the amount of any such new or increased taxes.

Article 4 Benefits, Limitations and Exclusions

- 4.01 Subject to the limitations and exclusions in this Contract, Monitor shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. Monitor may use dental consultants to determine generally accepted dental practice standards. Waiting periods, if any, for specific services are shown in Appendix A.

- 4.02 **Patient Copayment** Monitor's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Appendix A. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Monitor shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.
- 4.03 **Limitations on All Benefits – Optional Services** Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- 4.04 No change in Benefits will become effective during a Contract Term unless Applicant and Monitor agree in writing.
- 4.05 **Exclusions** Monitor does not pay Benefits for:
- a) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
 - b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).
 - c) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.
 - d) Any Single Procedure started before the patient is covered under this program.

- e) Prescribed drugs, medication or painkillers.
- f) Experimental procedures.
- g) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) Services for any disturbance of the temporomandibular joints (jaw joints).
- k) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- l) For services provided outside the United States, its territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.
- m) The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under this dental plan.

4.06 Diagnostic and Preventive Benefits (Type I Procedures) Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal scaling in the presence of inflamed gums is considered to be a Basic Service for payment provisions); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in teeth for the purpose of preventing decay).

4.07 Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

- a) Monitor will not pay for more than one (1) cleaning, including periodontal cleanings, done in any six (6) month period that the Enrollee is covered by any Monitor program.

- b) Monitor will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any Monitor program.
- c) Full-mouth x-rays or panographic x-rays will be provided when required by the Dentist, but no more than one set each 36 month period will be paid by Monitor.
- d) Bitewing x-rays are limited to one set each 12 month period.
- e) Topical applications of fluoride are limited to one each 12 month period when provided to Enrollees under age 19; furthermore, Monitor will not pay for topical application of fluoride for an Enrollee 19 years or older.
- f) Sealant applications to any one posterior permanent tooth are limited to one each 36 month period.

4.08 **Basic Benefits (Type II Procedures)** Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Preventative:	space maintainers.
[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Restorative:	Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services.
Palliative:	treatment to relieve pain.

4.09 **Limitations on Basic Benefits (Type II Procedures)** Monitor will not pay for space maintainers for baby teeth for an Enrollee 16 years or older.

4.10 **Major Benefits (Type III Procedures)** Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

[**Oral Surgery:** extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]

[**Endodontics:** pulp capping, pulpotomy, root canal therapy, and periapical services.]

[**Periodontics:** surgical services (including unusual postoperative services) and adjunctive periodontal services.]

Prosthodontics: Complete & partial dentures (including routine post delivery care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.

Orthodontics: The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

4.11 **Limitations on Prosthodontic Benefits**

- a) The maximum amount paid by Monitor for each Enrollee during the Contract Year is shown in Appendix A.
- b) Monitor will not pay to replace any crown, jacket or cast restoration that the patient received in the previous 5 years.
- c) Monitor will not pay to replace any bridge or denture that the patient received in the previous 5 years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
- d) Monitor limits Benefits for dentures to a standard partial or complete denture. A “standard” denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- e) Monitor will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Monitor will credit the cost of a standard complete or partial denture that would have been allowed under

this plan toward the cost of an implant and related services (copayments apply.)

4.12 Limitations on Orthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the Contract Year and the Enrollee's lifetime is shown in Appendix A.
- b) Payment of Orthodontics is provided monthly.
- c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.
- e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.
- f) X-rays or extractions are not subject to the Orthodontic maximum.
- g) Surgical procedures are not subject to the Orthodontic maximum.
- h) Orthodontic Benefits are limited to Dependent Enrollees within ages shown in Appendix A.
- i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for [12] consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant's previous plan.

Article 5 Deductible, Maximum and Coordination of Benefits

- 5.01 **Deductible** Monitor will not pay Benefits for the deductible amount shown in Appendix A of the Dentist's UCR fees for services received [for the term of the Enrollee's policy contract or per contract year]. Services, to which a deductible is **not** applied, if any, are shown in Appendix A. Only fees an Enrollee pays for services that are described under Article 4 shall count toward the deductible.
- 5.02 **Maximum** Monitor shall pay a maximum amount shown in Appendix A each [Contract Year] per Enrollee for all Benefits as listed.
- 5.03 **Coordination of Benefits** Monitor coordinates the Benefits under this Contract with an Enrollee's benefits under any other group pre-paid program

or insurance policy. Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's total fees for covered services. If this is the "primary" program, Monitor shall not reduce Benefits. But if the other program is the primary one, Monitor shall reduce Benefits otherwise payable under this Contract. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under Article 4.

The following rules determine which is the "primary" program:

- a) If the other program is not primarily a dental program, this program is primary.
- b) If the other program is a dental program, the following rules are applied:
 - 1. The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
 - 2. The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.
- c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Article 6 Conditions Under Which Benefits Shall Be Provided.

- 6.01 **Choice of a Dentist** An Enrollee may choose any Dentist, but Monitor does not guarantee that any particular Dentist shall be available. The Enrollee is responsible for verifying whether the treating Dentist is a Participating

Dentist, if necessary. A directory of Participating Dentist will be provided to the Applicant, if necessary.

- 6.02 **Clinical Examination** Before approving a claim, Monitor may obtain, to such extent as may be lawful, from any Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to an Enrollee as Monitor may require to administer the claim. Or Monitor may require that an Enrollee be examined by a dental consultant retained by Monitor in or near his community or residence. Such information and records shall be kept confidential.
- 6.03 **Notice of Claim Forms** Monitor shall furnish to any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for payment of Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Monitor at the address shown thereon. If Monitor does not furnish the form within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in Section 6.05 of this Contract shall be deemed to have been complied with upon the submission to Monitor, within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made, within the time established in said section for filing proof of loss.
- 6.04 **Predetermination** A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. Monitor shall predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term nor beyond the date the patient's coverage ends.
- 6.05 **Proof of Loss** Affirmative proof of loss must be furnished to Monitor at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of loss within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss within such time and that such proof of loss was furnished as soon as reasonably possible.
- 6.06 **Time of Payment** Indemnities payable under this Contract for any loss other than loss for which this Contract provides any periodic payment shall be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Contract provides periodic payment shall be paid monthly and any balance remaining upon the termination of liability shall be paid immediately upon receipt of due written proof. Claims not paid within forty-five (45) days of due written proof of loss are subject to a charge of 1 and ½ percent interest per month.

- 6.07 **Review of Claim Denial** Monitor shall notify the Primary Enrollee if any Benefits are denied for services submitted on an Attending Dentist's Statement under Section 6.03, stating the reason(s) for denial. An Enrollee has 60 days after receiving a notice of denial to appeal it by writing to Monitor giving reasons why the denial was wrong. The Enrollee may also ask Monitor to examine any records to aid his appeal.

Monitor shall make a full and fair review. Monitor may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of the local dental society in the patient's area. A decision shall be sent to the Primary Enrollee within 30 days after Monitor receives the request for appeal, unless it is referred to a peer review committee or other unusual circumstances arise. In no event shall the decision take longer than 120 days.

- 6.08 **Termination of Benefits on Loss of Eligibility** Monitor shall not pay for Benefits for any services received by a patient who is not an Enrollee at the time of treatment except for Single Procedures started when the patient was covered. Applicant shall reimburse Monitor for any payments made because of errors in Applicant's reports under Section 2.01.
- 6.09 **To Whom Benefits Are Paid** Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him.

Article 7 General Contract Provisions

- 7.01 **Contract Changes** This Contract, including the Application and the attachments listed in Article 9, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract shall be valid unless approved by an executive officer of Monitor.
- 7.02 **Severability** If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract shall remain in full force and effect.
- 7.03 **Conformity With State Laws** All legal questions about this Contract shall be governed by the State of [New York] where the Contract was entered into and is to be performed. Any part of this Contract which, on its Effective Date,

conflicts with the laws of [New York] hereby amended to conform to the minimum requirements of such laws.

- 7.04 **Effect of Misstatements on Application** In the absence of fraud, all statements made by the Applicant or Enrollee shall be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Applicant or Enrollee, a copy of which has been furnished to such Applicant or Enrollee.
- 7.05 **Legal Actions** No action at law or in equity shall be brought to recover on this Contract before 60 days after proof of loss has been filed in accordance with requirements of this Contract; nor shall an action be brought at all unless brought within three (3) years after expiration of the time within which proof of loss is required by this Contract.
- 7.06 **Not in Lieu of Workers' Compensation** This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.
- 7.07 **Certificate of Insurance** Monitor shall issue to the Applicant for delivery to each Primary Enrollee a certificate summarizing the Benefits to which they are entitled and to whom Benefits are payable. The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract shall materially affect any Benefits described in the certificate, new certificates or riders showing the change shall be issued.
- 7.08 **Publications About Program** Applicant and Monitor agree to consult as is reasonable practical on all material published or distributed about this Contract. No material shall be published or distributed which conflicts with the terms of this Contract.
- 7.09 **Professional Relationship** Applicant and Monitor agree to permit and encourage the professional relationship between Dentist and patient to be maintained without interference.
- 7.10 **Notice; Where Directed** All formal notice under this Contract must be in writing and sent by first-class United States mail, overnight delivery service, or person delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.
- 7.11 **Indemnification** Applicant shall indemnify, defend and hold harmless Monitor, its directors, officers, employees, agents and affiliated companies against any and all claims, demands liabilities, costs damages and causes of action or administrative proceedings whatsoever, including reasonable

attorney's fees, arising from Applicant's negligent performance or non-performance of its obligations under this Agreement.

Monitor shall indemnify, defend and hold harmless Applicant and its employees, members and agents, against any and all claims demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Monitor's negligent performance or non-performance of its obligations under this Agreement.

Article 8 Terminations, Renewal and Continuation

8.01 This Contract may be terminated only as follows:

- a) By Applicant or Monitor, at the end of a Contract Term upon 60 days written notice. If Monitor desires to change Premiums or Benefits at the end of a Contract Term, it shall give Applicant 60 days written notice, which shall terminate the Contract unless amended by mutual consent.
- b) By Monitor
 - (i) Upon 30 days written notice if Applicant fails to furnish Monitor a list of all Enrollees as required under Section 2.01; or
 - (ii) Upon 30 days written notice if Applicant fails to permit Monitor to inspect Applicant's records as called for under Section 2.01; or
 - (iii) Upon 30 days written notice if Applicant fails to pay or remit (if plan is voluntary) Premiums, in the amount and manner required by Article 3.
- c) By Monitor, if Applicant reports fewer than the Minimum Number of Primary Enrollees shown in Appendix A for three (3) consecutive months. Monitor must give Applicant notice within 15 days after receiving the list of Primary Enrollees, which shows that Monitor may terminate on this basis.

8.02 If the Contract is terminated under Section 8.01 (b), Applicant shall owe Monitor the greater of:

- a) All unpaid Premiums due before the Contract was terminated, or
- b) A plus B minus C where

A equals all Benefits paid during the Current Contract Term before the Contract was terminated,

B equals 25% of A to compensate Monitor for its costs of operating the program, and

C equals any Premiums in fact paid by Applicant during the Contract Term.

- [8.03 If applicant notifies Monitor that it intends to terminate the Contract on any day other than the final day of the Contract Term, Section 8.02 shall apply as if Monitor terminated the Contract under Section 8.01 (b) because Applicant failed to pay Premiums.]
- 8.04 Monitor shall not be required to Predetermine services if the Contract is terminated for any cause nor shall Monitor be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while the contract was in effect.
- 8.05 **Continuation of Coverage under COBRA** When the Eligible Persons of an Applicant are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the payments specified in Article 3 Monitor agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this provision.
- a) For purposes of this provision, each of the following shall constitute a “Qualifying Event”:
- (1) Termination of a Primary Enrollee’s employment with Applicant (other than for gross misconduct), or a reduction in the number of hours worked by the Primary Enrollee to less than the minimum number of hours required.
 - (2) Death of a Primary Enrollee.
 - (3) Divorce or legal separation from a Primary Enrollee.
 - (4) A Primary Enrollee becoming entitled to Medicare benefits.
 - (5) A dependent child ceasing to meet the description of dependent child.
 - (6) A bankruptcy proceeding under Title 11, United States Code with respect to the Applicant, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee (who retired on or before the date of substantial elimination of

coverage), or of the Dependent Enrollees of a retired Primary Enrollee.

- b) Primary Enrollees or Dependent Enrollees whose coverage under this program is terminated by reason of a Qualifying Event described in Section (a) (1) of this provision may elect to continue coverage for 18 months following the month in which the Qualifying Event occurs, or for 29 months following the month in which the Qualifying Event occurs in the case of Primary Enrollees or Dependent Enrollees who are determined under Title II or XVI of the Social Security Act to have been disabled at the time the Qualifying Event occurs, provided notice of such determination is given to Monitor during the initial 18 months and within 60 days after the date of the determination, and provided further that extended coverage for disability terminates the month that begins more than 30 days after the date of the final determination that the person is no longer disabled.
- c) Dependent Enrollees whose coverage under this program is terminated by reason of any of the Qualifying Events described in Section (a) (2) through (5) of this provision may elect to continue their coverage for 36 months following the month in which the Qualifying Event occurs. However, persons who elect to continue their coverage based on a Qualifying Event described in Section (a) (1) of this provision, and for whom a second Qualifying Event described in Section (a) (2) through (5) of this provision occurs within the next 18 months, may elect to continue their coverage for a maximum of 36 months following the month in which the first Qualifying Event occurred (in the case of a second Qualifying Event described in Section (2), (3) or (5), or for a maximum of 36 months following the month in which the second Qualifying Event occurred (in the case of a Qualifying event described in Section (a) (4)).
- d) Primary Enrollees or Dependent Enrollees whose coverage under this program is terminated by reason of a Qualifying Event described in Section (a) (6) of this provision may elect to continue their coverage for 36 months after the date of death of the retired Primary Enrollee (in the case of Dependent Enrollees of a retired Primary Enrollee).
- e) Continued coverage can be elected only by notice to Applicant, which must be given no later than 60 days after the a termination of coverage by reason of a Qualifying Event, or within 60 days after the Enrollee receives from Applicant a notice about his or her rights to continued coverage because of the particular Qualifying Event, whichever is later. Persons for whom a Qualifying Event described in Section (a) (3) or (5) occurs must report it to Applicant within 60 days, or lose their right to elect continued coverage.

- f) Continued coverage elected by a person under this provision shall be effective as of the first day of the month following the applicable Qualifying Event described in Section 1 above. However, Benefits shall not be available to a person electing continuing coverage until Monitor receives the data about such person required in the Contract, along with all Premiums then currently payable for such person. Monitor shall not, in any event, make Benefits available under this provision with respect to any person for whom such information and Premiums are not received by Monitor within sixty 60 days after the date such person is required by section (e) of this provision to notify Applicant of his or her election.
- g) Continued coverage for persons under this provisions shall be the same as the coverage for similarly situated Enrollees under the Contract, and if coverage is modified for such Enrollees it shall also be modified in the same manner for persons having continued coverage under this provision.
- h) A person's continued coverage elected under sections b, c or d of this provision shall terminate on the last day of the month in which any of the following events first occurs:
 - (1) The period of continued coverage specified in section b, c or d expires.
 - (2) This Contract terminates.
 - (3) Applicant fails to pay Premiums for the person as specified in Article 3 of the Contract.
 - (4) The person with continued coverage becomes covered for dental benefits under another group health plan (as an employee, member or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such person.
 - (5) The person becomes eligible for Medicare benefits.
- i) Once continued coverage under this provision is terminated, it cannot be reinstated.

Article 9 Attachments

These documents are attached to this Contract and made a part of it:

Appendix A Group Variables

[Appendix B Monitor Uniform Procedure Code and Nomenclature]

Copy of the Application

Appendix A Group Variables

Applicant Name: [Doe & Doe, Ltd.]

Address: [P. O. Box 14000]
[Jackson, Mississippi 39236]

Group Number: [25-1271]

Effective Date: [January 1, 2011]

Contract Term: [January 1, 2011 through December 31, 2011]

Minimum Number of Hours: [20 hours per week]

Eligibility Period: [Three (3) months]

Effective Day of Month: [First day of the month following completion of eligibility]

Open Enrollment Period: [January]

Premiums

Monthly Amount:

For each Primary Enrollee: [\$19.87]

For each Primary Enrollee with
One Dependent Enrollee: [\$39.71]

For each Primary Enrollee with more than
One Dependent Enrollee: [\$59.73]

Payment Breakdown:

Primary Enrollee shall pay [100%] of Premiums for personal coverage. Primary Enrollee shall pay [100%] of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits:

	Policy Year		
	1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	[80%]	[90%]	[100%]
Type II Procedures (Basic Benefits)			
Preventative	[60%]	[70%]	[80%]
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Restorative	[60%]	[70%]	[80%]
Palliative	[60%]	[70%]	[80%]
Type III Procedures			
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Prosthodontics (Removable & Fixed)	[0%]	[40%]	[50%]
Orthodontics	[0%]	[40%]	[50%]

These percentages are based on the Contract Allowance.

Note – Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

Waiting Periods:

Type I Procedures	[0 months]
Type II Procedures	[0 months]
Type III Procedures	[12 months]

Orthodontic Benefits are limited to Dependent Enrollee children 6 years to age 19.

Deductible Amount

For each Enrollee	[\$100.00 for the term of each Enrollee's policy per [Contract Year]]
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Any deductible for Orthodontic Benefits an Enrollee satisfied under the Applicant's prior plan will be credited toward the deductible under this plan.

Maximum Amount:

- [\$600.00] per Enrollee per [Contract Year] for Prosthodontic Benefits.
- [\$350.00] per Enrollee per [Contract Year] for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per Lifetime for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per [Contract Year] for All Benefits (Type I, II, & III Combined).
- [\$500.00] per Enrollee age 65 or older per [Calendar Year] for Prosthetics or the repair thereof.]

Monitor will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination:

Less than [Ten(10)] Primary Enrollee(s).

State of Issue: [New York]

APPENDIX B

MONITOR UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a Complete list of the dental procedures for which benefits are payable under this policy and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120	Periodic oral examination.	\$	[21]
0130	Emergency oral examination.		[21]

Radiographs

0210	Intraoral - complete series (including bitewings).		[50]
0220	Intraoral periapical - first film.		[10]
0230	Intraoral periapical - each additional film up to 12.		[6]
0240	Intraoral - occlusal film.		[11]
0250	Extraoral - first film.		[10]
0260	Extraoral - each additional film.		[13]
0270	Bitewing - single films.		[12]
0272	Bitewings - two films.		[16]
0274	Bitewings - four films.		[22]
0330	Panographic film.		[44]

Tests and Laboratory Examinations

0470	Diagnostic cast.		[40]
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Preventive

Dental Prophylaxis

1110	Prophylaxis - adult.		[32]
1120	Prophylaxis - child.		[26]

Topical Fluoride Treatment (Office Procedure)

1201	Topical application of fluoride (including prophylaxis) - child.		[38]
1202	Topical application of fluoride (including prophylaxis) - adult.		[44]
1203	Topical application of fluoride (excluding prophylaxis) - child.		[13]
1204	Topical application of fluoride (excluding prophylaxis) - adult.		[13]

Other Preventive Services

1351	Sealant - per tooth.		[16]
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BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510	Space Maintainer - fixed unilateral.	\$	[131]
1515	Space Maintainer - fixed-bilateral.		[231]
1520	Space Maintainer - removable-unilateral.		[170]
1525	Space Maintainer - removable-bilateral.		[200]
1550	Recementation of space maintainer.		[32]

Restorative

Amalgam Restorations (including Polishing)

2110	Amalgam - one surface, primary.	[34]
2120	Amalgam - two surfaces, primary.	[43]
2130	Amalgam - three surfaces, primary.	[54]
2140	Amalgam - one surface, permanent.	[32]
2150	Amalgam - two surfaces, permanent.	[42]
2160	Amalgam - three surfaces, permanent.	[53]

Silicate Restorations

2210	Silicate cement - per restoration.	[21]
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Filled or Unfilled Resin Restorations

2310	Acrylic or plastic.	[30]
2330	Resin - one surface.	[37]
2331	Resin - two surface.	[47]
2332	Resin - three surfaces.	[58]

Other Restorative Services.

2940	Sedative filling.	[34]
2950	Crown buildup - pin retained.	[84]
2951	Pin retention - per tooth, in addition to restoration.	[19]
2953	Cast post as part of crown.	[144]
2954	Prefabricated post and core in addition to crown.	[125]
2970	Temporary (fractured tooth).	[84]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures			
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).		[237]
Alveoloplasty - Surgical Preparation of Ridge for Dentures			
7310	Alveoloplasty in conjunction with extractions - per quadrant.		[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.		[96]
Vestibuloplasty			
7340	Vestibuloplasty - ridge extension (secondary epithelialization).		[151]
Surgical Incision			
7510	Incision and drainage of abscess - intraoral soft tissue.		[50]
[Endodontics]			
Pulp Capping			
3110	Pulp cap - direct (excluding final restoration).		[26]
3120	Pulp cap - indirect (excluding final restoration).		[21]
Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration).		[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)			
3310	One canal (excluding final restoration).	\$	[265]
3320	Two canals (excluding final restoration).		[324]
3330	Three canals (excluding final restoration).		[418]
3340	Four or more canals (excluding final restoration).		[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).		[150]
Periapical Services			
3410	Apicoectomy (per tooth) - first root.		[248]
[Periodontics]			
Surgical Services (Including Unusual Postoperative Services)			
4210	Gingivectomy or gingivoplasty - per quadrant.		[105]
4211	Gingivectomy or gingivoplasty - per tooth.		[63]
4220	Gingival curettage, by report.		[42]
4240	Gingival flap curettage (including root planning).		[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.		[315]
Adjunctive Periodontal Services			
4340	Root Planning - entire mouth.		[296]
4341	Root Planning - per quadrant.		[74]
4910	Periodontal Prophylaxis.		[42]
Adjunctive General Services			
Unclassified Treatment			
9110	Palliative (emergency) treatment of dental pain - minor procedures.		[32]

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510	Inlay, metallic - one surface (excluding gold).	[147]
2520	Inlay, metallic - two surfaces (excluding gold).	[171]
2530	Inlay, metallic - three surfaces (excluding gold).	[204]

Crowns - Single Restorations Only

2710	Crown - Plastic (acrylic).	[50]
2721	Crown - resin with predominantly base metal.	[95]
2740	Crown - porcelain/ceramic substrate.	[250]
2752	Crown - porcelain fused with noble metal.	[224]
2810	Crown - 3/4 cast metallic.	[250]
2830	Crown - Stainless steel.	[275]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]

Vestibuloplasty

7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
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Surgical Incision

7510	Incision and drainage of abscess - intraoral soft tissue.	[50]]
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[Endodontics

Pulp Capping

3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]

Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration).	[63]	
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)			
3310	One canal (excluding final restoration).	\$ [265]	
3320	Two canals (excluding final restoration).	[324]	
3330	Three canals (excluding final restoration).	[418]	
3340	Four or more canals (excluding final restoration).	[498]	
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]	

Periapical Services			
3410	Apicoectomy (per tooth) - first root.	[248]]	

[Periodontics

Surgical Services (Including Unusual Postoperative Services)			
4210	Gingivectomy or gingivoplasty - per quadrant.	[105]	
4211	Gingivectomy or gingivoplasty - per tooth.	[63]	
4220	Gingival curettage, by report.	[42]	
4240	Gingival flap curettage (including root planning).	[158]	
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]	

Adjunctive Periodontal Services			
4340	Root Planning - entire mouth.	[296]	
4341	Root Planning - per quadrant.	[74]	
4910	Periodontal Prophylaxis.	[42]]	

Prosthodontics (Removable)

Complete Dentures (Including Routine Post Delivery Care)			
5110	Complete upper.	[261]	
5120	Complete lower.	[259]	
5130	Immediate upper.	[289]	
5140	Immediate lower.	[277]	

Partial Dentures (Including Routine Post Delivery Care)			
5211	Upper partial - acrylic base (including any conventional clasps and rests).	[313]	
5212	Lower partial - acrylic base (including any conventional clasps and rests).	[315]	
5213	Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).	[236]	
5214	Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).	[236]	
5216	Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).	[315]	
5281	Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).	[126]	

Adjustments to Dentures

5410	Adjust complete denture - upper (more than six months after installation).		[15]
5411	Adjust complete denture - lower (more than six months after installation).	\$	[16]
5421	Adjust partial denture - upper (more than six months after installation).		[14]
5422	Adjust partial denture - lower (more than six months after installation).		[15]

Repairs to Dentures

5520	Replace missing or broken teeth - complete denture (each tooth)		[42]
5640	Replace broken teeth or denture, no other repairs.		[46]
5650	Add tooth to existing partial denture.		[67]
5660	Add clasp to existing partial denture.		[75]

Denture Reline Procedures

5730	Reline complete upper denture (chair side).		[58]
5731	Reline complete lower denture (chair side).		[66]
5740	Reline upper partial denture (chair side).		[63]
5741	Reline lower partial denture (chair side).		[63]
5750	Reline complete upper denture (laboratory).		[81]
5751	Reline complete lower denture (laboratory).		[82]
5760	Reline upper partial denture (laboratory).		[84]
5761	Reline lower partial denture (laboratory).		[79]

Other Removable Prosthetic Services

5820	Temporary partial - stayplate denture (upper).		[193]
5821	Temporary partial - stayplate denture (lower).		[205]

Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)

Bridge Pontics

6211	Pontic - cast predominantly base metal.		[197]
6241	Pontic - porcelain fused to predominantly base metal.		[210]
6251	Pontic - resin with predominantly base metal.		[213]

Bridge Retainers - Crowns

6710	Crown - resin.		[160]
6721	Crown - resin with predominantly base metal.		[171]
6751	Crown - porcelain fused to predominantly base metal.		[210]
6791	Crown - full cast predominantly base metal.		[208]

Other Fixed Prosthetic Services

6930	Recement bridge.		[42]
6940	Stress breaker.		[101]

Orthodontics (No Scheduled Maximums)

Minor treatment for tooth guidance

8110	Upper retainer.		
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8112 Lower retainer.
8120 Fixed appliance therapy.

Minor treatment to control harmful habits

8210 Removable appliance therapy.
8220 Fixed appliance therapy.

Interceptive orthodontic treatment

8360 Removable appliance therapy.
8370 Fixed appliance therapy.

Comprehensive orthodontic treatment-transitional dentition

8460 Class I malocclusion.
8470 Class II malocclusion.
8480 Class III malocclusion.

Comprehensive orthodontic treatment-permanent dentition

8560 Class I malocclusion.
8570 Class II malocclusion.
8580 Class III malocclusion.

Other orthodontic procedures

8650 Treatment of the atypical or extended skeletal case.
8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

9220 General anesthesia. \$ [116]

Monitor Life Insurance Company of New York

Dental Care Plan

[Doe & Doe, Ltd.]

Group Number: [25-1371]

Effective Date: [January 1, 2011]

Monitor Life Insurance Company of New York

70 Genesee Street
Utica, New York 13502
Telephone 800-422-6200

(Herein called the Company)

Certificate of Insurance of Your Group Dental Program

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Monitor Life Insurance Company of New York** ("Monitor") and cannot modify the Contract in any way.

President
Monitor Life Insurance Company of New York

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Monitor Life Insurance Company of New York

Group Highlights

Applicant Name: [Doe & Doe, Ltd.]

Address: [P. O. Box 14000]
[Utica, New York 13502]

Group Number: [25-1271]

Effective Date: [January 1, 2011]

Contract Term: [January 1, 2011 through December 31, 2011]

Minimum Number of Hours: [Not Applicable]

Eligibility Period: [Not Applicable]

Effective Day of Month: [First day of the month following completion of eligibility]

Open Enrollment Period: [January]

Premiums

Monthly Amount:

For each Primary Enrollee: [\$19.87]

For each Primary Enrollee with
One Dependent Enrollee [\$39.71]

For each Primary Enrollee with more than
One Dependent Enrollee [\$59.73]

Payment Breakdown:

Primary Enrollee shall pay [100%] of Premiums for personal coverage. Primary Enrollee shall pay [100%] of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits:

	Policy Year		
	1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	[80%]	[90%]	[100%]
Type II Procedures (Basic Benefits)			
Preventative	[60%]	[70%]	[80%]
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Restorative	[60%]	[70%]	[80%]
Palliative	[60%]	[70%]	[80%]
Type III Procedures			
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Prosthodontics (Removable & Fixed)	[0%]	[40%]	[50%]
Orthodontics	[0%]	[40%]	[50%]

These percentages are based on the Contract Allowance.

Note - Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

Waiting Periods:

Type I Procedures	[0 months]
Type II Procedures	[0 months]
Type III Procedures	[12 months]

Orthodontic Benefits are limited to Dependent Enrollee children six (6) years to age 19.

Deductible Amount

For each Enrollee	[\$100.00 for the term of each Enrollee's policy per [Contract Year]]
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Any deductible for Orthodontic Benefits an Enrollee satisfied under the Applicant's prior plan will be credited toward the deductible under this plan.

Maximum Amount:

- [\$600.00] per Enrollee per [Contract Year] for Prosthodontic Benefits.
- [\$350.00] per Enrollee per [Contract Year] for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per Lifetime for Orthodontic Benefits.
- [\$1,000.00] per Enrollee per [Contract Year] for All Benefits (Type I, II, & III Combined)
- [\$500.00] per Enrollee age 65 or older per [Calendar Year] for Prosthetics or the repair thereof.]

Monitor will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination:

Less than [Ten (10)] Primary Enrollee(s).

State of Issue: [New York]

Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

- 1.01 **“Applicant”** – the employer, association or other organization or group contracting to obtain Benefits.
- 1.02 **“Approved Amount”** – the total fee chargeable for a Single Procedure.
- 1.03 **“Attending Dentist’s Statement”** – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.
- 1.04 **“Benefits”** – the amounts that Monitor will pay for dental services under Article 4.
- 1.05 **“Calendar Year”** – the 12 months of the year from January 1 through December 31.
- 1.06 **“Contract”** – this agreement between Monitor and Applicant, including the Application and the attachments listed in Article 9.
- 1.07 **“Contract Allowance”** – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist’s submitted fee, and the Scheduled Maximum, if any, and the Dentist’s fee filed with Monitor in the Participating Dentist Agreement, if any, or the UCR.
- 1.08 **“Contract Term”** – the period during which the Contract is in effect, as shown in the Group Highlights page.
- 1.09 **“Contract Year”** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and maximums will be determined using this 12 month period rather than on a calendar year basis.
- 1.10 **“Dentist”** – a person licensed to practice dentistry when and where services are performed.
- 1.11 **“Dependent Enrollee”** – an Eligible Dependent enrolled in the plan to receive Benefits.
- 1.12 **“Effective Date”** – the date the program starts, as shown in the Group Highlights page.
- 1.13 **“Eligible Dependent”** – a dependent of an Eligible Person eligible for Benefits under Article 2.
- 1.14 **“Eligible Person”** – a person as listed in The Group Highlights page, designated by the Applicant as eligible for Benefits under Article 2.
- 1.15 **“Enrollee”** – an Eligible Person (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.
- 1.16 **“Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist”** – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. A Non-Participating Dentist may charge more

than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.

- 1.17 **“Open Enrollment Period”** – the month(s) of the year, as shown in the Group Highlights page, during which Eligible Persons may change coverage for the next [Contract year].
- 1.18 **“Predetermination”** – Monitor shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.
- 1.19 **“Preferred, Network, Contracting, Participating Dentist”** – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. See Non-Participating Dentist.
- 1.20 **“Premiums”** – the amounts payable monthly by the Applicant as required in the Contract.
- 1.21 **“Primary Enrollee”** – an Eligible Person enrolled in the plan to receive Benefits.
- 1.22 **“Procedure Number”** – the number given to a Single Procedure in the Monitor Dental Uniform Procedure Code and Nomenclature attached as Appendix A.
- 1.23 **“Qualifying Family Status Change”** – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.
- 1.24 **“Scheduled Maximum”** – the maximum Contract Allowance for each dental procedure, as shown in Appendix A, if any.
- 1.25 **“Single Procedure”** – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).
- 1.26 **“UCR”** – “usual, customary and reasonable” which have the following meanings:

Usual – A “usual” fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is “customary” when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic areas determined by Monitor to be relevant. Customary fees may be determined on the basis of fees filed with Monitor by Participating Dentist. A Customary fee for a Participating Dentist is that fee which is approved by Monitor in the terms of the Participating Dentist Agreement.

Reasonable – A fee is “reasonable” if it is “usual” and “customary” or if it falls above “usual” and “customary” or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

- 1.27 **“Uniform Procedure Code”** – the Monitor Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.
- 1.28 **“We, Our, or Us”** – Monitor, and will be used without respect to capitalization.
- 1.29 **“You, Your, Yours”** – the Primary Enrollee and will be used without respect to capitalization.

Choice of Dentist

Monitor offers you a choice of selecting a Dentist from our panel of Participating Dentists, if applicable, or you may choose a Non-participating Dentist.

A directory of Participating Dentists is available from your employer. You are responsible for verifying whether the Dentist you select is a Participating Dentist. Dentists are regularly added to the panel so a Participating Dentist may not yet be listed. Additionally, you should always confirm that a listed Dentist is still a Participating Dentist.

You may choose to go to any Dentist. Even if you choose a Participating Dentist from our panel, Monitor cannot guarantee that a particular Dentist will be available.

There may be a difference in the out-of-pocket cost you pay if your Dentist is not a Participating Dentist. A Participating Dentist has contractually agreed not to charge you any amount for services above the Contract Allowance. We pay your Benefits based on the Contract Allowance less any deductibles or maximums that may apply.

If a Dentist is not a Participating Dentist, the amount charged to you may be above that charged by our Participating Dentists. When we pay Benefits for services provided by Non-participating Dentists, we will allow the Contract Allowance, or the fee paid to Participating Dentists. You will then be responsible for any extra amount charged by this Dentist over what Benefits we will pay in addition to any deductibles and maximums specified by the plan. This is called balance billing, that is, the Dentist may bill you for the balance after Monitor’s payment is made.

Who Is Eligible?

Eligibility for Enrollment

All present, permanent members of the association are eligible on the Effective Date.

All future, permanent members of the association shall become eligible on the calendar day of the month shown on the Group Highlights page after they have obtained membership.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Dependents are your:

- a) Lawful spouse;
- b) Unmarried dependent children from birth to their 19th birthday, or 25th birthday, if a full-time student in an accredited school.

“Children” includes natural children, stepchildren, adopted children and foster children. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the moment of placement in the physical custody of the Eligible Person, as certified by the agency making the placement. A child shall automatically be covered for 31 days after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

An unmarried child 19 years or older may continue to be eligible as a dependent if the child is:

- a) Not self-supporting because of mental incapacity or physical handicap that began before age 19; and
- b) The child must be mostly dependent on the Eligible Person for support and maintenance.

Proof of these facts must be given to Monitor or your association within 31 days if it is requested. Proof will not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

Enrollment Requirements

If you are paying all or a portion of premiums for yourself or your dependents then:

- a) You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.
- b) All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period.
- c) If you elect dependent coverage, you must enroll all of your Eligible Dependents for coverage.
- d) You pay Premiums for Dependent Enrollees in the manner elected by your association and approved by Monitor until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be dropped or changed at any time other than during an Open Enrollment Period or if there is a Qualifying Family Status Change.
- e) If both you and your spouse are Eligible Persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.

Loss of Eligibility

Your coverage ends on the last day of the month your membership in the association terminates, or immediately when this program ends. Your dependents’ coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this certificate.

Continuation of Benefits

Monitor does not pay Benefits for services received after your coverage ends. But Monitor will pay for Single Procedures started before that date.

[Strike, Lay-off and Leave of Absence]

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family Medical Leave Act of 1993*. If you return to work within six (6) months you will become eligible on the first day of the month following your return. If you are gone more than six (6) months, you will have to re-qualify for coverage just like a new employee. No matter when you return, any deductibles and maximums will start over, just like a new employee.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family Leave Act of 1993. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred. **Important:** The Family Medical Leave Act does **not** apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.]

[Optional Continuation of Coverage (COBRA)]

When the Eligible Persons of the employer are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the premium payments, Monitor agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this section.

- a) Right to Continue. Coverage may continue in accordance with the following provisions when:
- (1) You or your Dependent Enrollee becomes ineligible for coverage under the Contract due to a Qualifying Event shown below; and
 - (2) The Contract remains in force.

“Qualifying Event” means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of coverage under this Contract:

- (1) Your termination of employment.
- (2) Your death.
- (3) Divorce or legal separation from you.
- (4) You becoming entitled to Medicare benefits.
- (5) A dependent child ceasing to meet the description of a dependent child.
- (6) A bankruptcy proceeding under Title 11, United States Code with respect to the employer, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee (who retired on or before the date of substantial elimination of coverage), or of a Dependent Enrollee of a retired Primary Enrollee.

“Qualified Beneficiary” means you and any of your Dependent Enrollees who are entitled to continue coverage under the Contract, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) Is acquired during your 18 or 29 month continuation period; and
- (2) Is enrolled for coverage in accordance with the terms of the Contract.

But it does not include your new spouse, stepchild or foster child acquired during the continuation period: whether or not the new Dependent is enrolled for coverage.

b) Continuation Periods. The maximum period of continued coverage for each Qualifying Event shall be as follows:

- (1) Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and any of your Dependent Enrollees may be continued for up to 18 months from the date employment ended. Termination of employment includes a reduction in hours or retirement.

Exceptions:

- (i) Misconduct. If your termination of employment is for gross misconduct, coverage may not be continued for you or any of your Dependent Enrollees.
- (ii) Disability. “Disability” or “Disabled” as used in this section shall be defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If you:

- (a) Become disabled by the 60th day after your employment ends; and
- (b) Are covered for Social Security Disability Income benefits; then coverage for you and any of your Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

If your Dependent Enrollee:

- (a) Becomes disabled by the 60th day after your employment ends; and
- (b) Is covered for Social Security Disability Income benefits; then coverage for that Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

You must send the employer a copy of the Social Security Administration’s letter:

- (a) Within 60 days after they find that you or your Dependent Enrollee is disabled, and before the 18 month continuation period expires; and again
- (b) Within 30 days after they find that he or she is no longer disabled.

(iii) Subsequent Qualifying Event. If your Dependent:

- (a) Is a Qualified Beneficiary; and
 - (b) Has a subsequent Qualifying Event during the 18 or 29 month continuation period; then coverage for that Dependent Enrollee may be continued for up to 36 months, from the date your employment ended.
- (2) Loss of Dependent Eligibility. If a Dependent Enrollee's eligibility ends, due to a Qualifying Event other than your termination of employment; then that Dependent Enrollee's coverage may be continued for up to 36 months, from the date of the event. Such events may include:
- (i) Your death, divorce, legal separation, or Medicare entitlement; and
 - (ii) A child reaching the age limit, getting married or ceasing to be a full-time student.

You must notify the employer within 60 days of divorce, a legal separation, or a child ceasing to be an eligible Dependent (as defined by the Contract). One or more subsequent Qualifying Events may occur during the Dependent Enrollee's 36 month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first event.

- (3) Medicare Entitlement. If your eligibility under the Contract ends when you become entitled to Medicare benefits; then coverage may not be continued for yourself. But coverage may be continued for any of your Dependent Enrollees for up to 36 months, from your Medicare entitlement date.

If your eligibility under the Contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement; then any of your Dependent Enrollees may continue coverage for up to:

- (i) 36 months from your Medicare entitlement date; or
- (ii) 18 months from the date your employment ended (whichever is later).

- c) Election. To continue coverage, you must notify the employer of such election within 60 days from the later of:

- (1) The date of the Qualifying Event;
- (2) The date of the loss of coverage; or
- (3) The date the employer sends notice of the right to continue.

Continued coverage elected under this section shall be effective the first day of the month following the applicable Qualifying Event. However, Benefits shall not be available to a person electing continuation until Monitor receives the data about such person required in the Contract, along with all Premiums then currently payable for such person. Monitor shall not, in any event, make benefits available under this section with respect to any person for whom such information and Premium are not received by Monitor within 60 days after the date such person is required to notify the employer of his or her election as stated above.

- d) Termination. Continued coverage will end at the earliest of the following dates:

- (1) The end of the maximum period for continued coverage shown above;
- (2) The date the Contract terminates;
- (3) The last day of the period for which Premium has been paid; if any Premium is not paid when due;
- (4) The date you or your Dependent Enrollee:
 - (i) Becomes covered under any other group dental plan; or
 - (ii) Become eligible for benefits for Medicare.

Once continued coverage ends; it cannot be reinstated.]

Deductible

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible.

Maximum Amount

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

Monitor will receive credit for any amounts paid for Orthodontic Benefits. Those amounts shall be deducted from the maximum paid by Monitor.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with your association is cancelled.

Premiums

You will be responsible for [100%] of the cost of premiums for yourself. You will be responsible for [100%] of the cost of premiums for your Dependent Enrollees.

Monitor may cancel this Program 30 days after written notice to you if monthly Premiums are not paid when due.

Benefits, Limitations & Exclusions

Subject to the limitations and exclusions in this Contract, Monitor shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. Monitor may use dental consultants to determine generally accepted dental practice standards. Eligibility periods, if any, for specific services are shown in Group Highlights.

Patient Copayment - Monitor's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Group Highlights. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Monitor shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.

Limitations on All Benefits – Optional Services. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

No change in Benefits will become effective during a Contract Term unless Applicant and Monitor agree in writing.

Exclusions - Monitor does not pay Benefits for:

- a) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).
- c) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.
- d) Any Single Procedure started before the patient is covered under this program.
- e) Prescribed drugs, medication or painkillers.
- f) Experimental procedures.
- g) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

- j) Services for any disturbance of the temporomandibular joints (jaw joints).
- k) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- l) For services provided outside the United States, its territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.
- m) The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under this dental plan.

Diagnostic and Preventive Benefits (Type I Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal scaling in the presence of inflamed gums is considered to be a Basic Service for payment provisions); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in teeth for the purpose of preventing decay).

Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

- a) Monitor will not pay for more than one (1) cleaning, including periodontal cleanings, done in any six (6) month period that the Enrollee is covered by any Monitor program.
- b) Monitor will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any Monitor program.
- c) Full-mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but no more than one set each 36 month period will be paid by Monitor.
- d) Bitewing x-rays are limited to one set each 12 months period.
- e) Topical applications of fluoride are limited to one (1) each twelve month period when provided to Enrollees under age 19; furthermore, Monitor will not pay for topical application of fluoride for an Enrollee 19 years of older.
- f) Sealant applications to any one posterior permanent tooth are limited to one (1) each 36 month period.

4.08 Basic Benefits (Type II Procedures) Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

Preventative: space maintainers.

[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Restorative:	Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services.
Palliative:	treatment to relieve pain.

Limitations on Basic Benefits (Type II Procedures) - Monitor will not pay for space maintainers for baby teeth for an Enrollee 16 years or older.

4.10 Major Benefits (Type III Procedures) Monitor shall pay or otherwise discharge the percentage shown in Appendix A of the Contract Allowance for the following services:

[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Prosthodontics:	Complete & partial dentures (including routine post delivery care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.
Orthodontics:	The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

Limitations on Prosthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] is shown in Group Highlights.
- b) Monitor will not pay to replace any crown, jacket or cast restoration, which the patient received in the previous 5 years.
- c) Monitor will not pay to replace any bridge or denture that the patient received in the previous 5 years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

- d) Monitor limits Benefits for dentures to a standard partial or complete denture. A “standard” denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- e) Monitor will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Monitor will credit the cost of a standard complete or partial denture that would have been allowed under this plan toward the cost of an implant and related services (copayments apply.)

Limitations on Orthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] and Enrollee’s lifetime is shown in Group Highlights.
- b) Payment of Orthodontics is provided monthly.
- c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.
- e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.
- f) X-rays or extractions are not subject to the Orthodontic maximum.
- g) Surgical procedures are not subject to the Orthodontic maximum.
- h) Orthodontic Benefits are limited to Dependent Enrollees within the ages shown in Group Highlights.
- i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for [12] consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant’s previous plan.

Coordination of Benefits

Monitor matches the Benefits under this program with your benefits under any other group pre-paid program or benefit plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist’s fees for covered services. If this is the “primary” program, Monitor shall not reduce Benefits. But if the other program is the primary one, Monitor shall reduce Benefits otherwise payable under this program. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under this program (see BENEFITS, LIMITATIONS & EXCLUSIONS).

How does Monitor determine which is the “primary” program?:

- a) If the other program is not primarily a dental program, this program is primary.

- b) If the other program is a dental program, the following rules are applied:
- (1) The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
 - (2) The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.
- c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Claims

Claims for Benefits must be filed on a standard Attending Dentist Statement that you or your Dentist may obtain from:

Monitor Life Insurance Company of New York
Attn: Membership Services
P.O. Box 16708
Jackson, Mississippi 39236
(800) 800-1397

Claims not paid within 45 days of due written proof of loss are subject to a charge of 1 and ½ percent interest per month.

Predeterminations

A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. Monitor will predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term or beyond the date of the patient's coverage ends.

Claims Appeal

Monitor will notify the Enrollee if any services submitted on a claim are denied coverage as Benefits, in whole or in part, stating the reason or reasons for the denial. Within 60 days after the receipt of a notice of denial the Enrollee may make a written request for a review of the denial by addressing a letter to Monitor stating the reason(s) for review or reconsideration and providing any pertinent documents which the Enrollee wishes Monitor to review.

Monitor will make a full and fair review. Monitor may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of your local dental society. A decision will be sent to the Primary Enrollee within 30 days after your request for an appeal is received, unless it is referred

to a peer review committee or other unusual circumstances arise. In no event will the decision take longer than 120 days.

Cancellation of Program

Monitor may cancel the program only:

- a) On an anniversary of the Effective Date; or
- b) If your association does not pay the monthly premiums; or
- c) If your association does not provide a list of who is eligible; or
- d) If less than the minimum number of Primary Enrollees required under the Contract reported eligible for three months or more.

Proof of Loss

Before approving a claim, Monitor will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Monitor, in or near his community or residence. Monitor shall in every case hold such information and records confidential.

Monitor will give any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Monitor. If the form is not furnished by Monitor within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Monitor, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Affirmative proof of loss must be furnished to Monitor at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of loss within that time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss and that such proof of loss was furnished as soon as was reasonably possible.

Time of Payment

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Subject to due written proof of loss, all accrued indemnities for loss which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payments will be made within 45 days if any claim is not denied for valid and proper reasons within 45 days after receipt of due written proof. The Company pays interest at the rate of 1 and ½ percent per month on the

amount of the claim until it is finally settled or adjudicated. If the Company does not pay a claim when due, the insured may bring action to recover benefits and any other damages.

To Whom Benefits are Paid

Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him.

Legal Actions

No action at law or in equity shall be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor shall an action be brought at all unless brought within 3 years from expiration of the time within proof of loss is required by the Contract.

This Certificate of Insurance constitutes only a summary of the dental service insurance Contract. The complete Contract must be consulted to determine the exact terms and conditions of coverage.

APPENDIX A

MONITOR UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a complete list of the dental procedures for which benefits are payable under this Certificate and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120	Periodic oral examination.	\$	[21]
0130	Emergency oral examination.		[21]

Radiographs

0210	Intraoral - complete series (including bitewings).	[50]
0220	Intraoral periapical - first film.	[10]
0230	Intraoral periapical - each additional film up to 12.	[6]
0240	Intraoral - occlusal film.	[11]
0250	Extraoral - first film.	[10]
0260	Extraoral - each additional film.	[13]
0270	Bitewing - single films.	[12]
0272	Bitewings - two films.	[16]
0274	Bitewings - four films.	[22]
0330	Panographic film.	[44]

Tests and Laboratory Examinations

0470	Diagnostic cast.	[40]
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Preventive

Dental Prophylaxis

1110	Prophylaxis - adult.	[32]
1120	Prophylaxis - child.	[26]

Topical Fluoride Treatment (Office Procedure)

1201	Topical application of fluoride (including prophylaxis) - child.	[38]
1202	Topical application of fluoride (including prophylaxis) - adult.	[44]
1203	Topical application of fluoride (excluding prophylaxis) - child.	[13]
1204	Topical application of fluoride (excluding prophylaxis) - adult.	[13]

Other Preventive Services

1351	Sealant - per tooth.	[16]
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BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510	Space Maintainer - fixed unilateral.	\$	[131]
1515	Space Maintainer - fixed-bilateral.		[231]
1520	Space Maintainer - removable-unilateral.		[170]
1525	Space Maintainer - removable-bilateral.		[200]
1550	Recementation of space maintainer.		[32]

Restorative

Amalgam Restorations (including Polishing)

2110	Amalgam - one surface, primary.		[34]
2120	Amalgam - two surfaces, primary.		[43]
2130	Amalgam - three surfaces, primary.		[54]
2140	Amalgam - one surface, permanent.		[32]
2150	Amalgam - two surfaces, permanent.		[42]
2160	Amalgam - three surfaces, permanent.		[53]

Silicate Restorations

2210	Silicate cement - per restoration.		[21]
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Filled or Unfilled Resin Restorations

2310	Acrylic or plastic.		[30]
2330	Resin - one surface.		[37]
2331	Resin - two surface.		[47]
2332	Resin - three surfaces.		[58]

Other Restorative Services.

2940	Sedative filling.		[34]
2950	Crown buildup - pin retained.		[84]
2951	Pin retention - per tooth, in addition to restoration.		[19]
2953	Cast post as part of crown.		[144]
2954	Prefabricated post and core in addition to crown.		[125]
2970	Temporary (fractured tooth).		[84]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.		[38]
7120	Each additional tooth.		[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal lap and removal of bone and/or section of tooth.	[76]	
7220	Removal of impacted tooth - soft tissue.		[109]
7230	Removal of impacted tooth - partially bony.		[153]
7240	Removal of impacted tooth - completely bony.		[\$184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).		[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures			
7310	Alveoloplasty in conjunction with extractions - per quadrant.		[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.		[96]
Vestibuloplasty			
7340	Vestibuloplasty - ridge extension (secondary epithelialization).		[151]
Surgical Incision			
7510	Incision and drainage of abscess - intraoral soft tissue.		[50]]
[Endodontics			
Pulp Capping			
3110	Pulp cap - direct (excluding final restoration).		[26]
3120	Pulp cap - indirect (excluding final restoration).		[21]
Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration).		[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)			
3310	One canal (excluding final restoration).	\$	[265]
3320	Two canals (excluding final restoration).		[324]
3330	Three canals (excluding final restoration).		[418]
3340	Four or more canals (excluding final restoration).		[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).		[150]
Periapical Services			
3410	Apicoectomy (per tooth) - first root.		[248]]
[Periodontics			
Surgical Services (Including Unusual Postoperative Services)			
4210	Gingivectomy or gingivoplasty - per quadrant.		[105]
4211	Gingivectomy or gingivoplasty - per tooth.		[63]
4220	Gingival curettage, by report.		[42]
4240	Gingival flap curettage (including root planning).		[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.		[315]
Adjunctive Periodontal Services			
4340	Root Planning - entire mouth.		[296]
4341	Root Planning - per quadrant.		[74]
4910	Periodontal Prophylaxis.		[42]]
Adjunctive General Services			
Unclassified Treatment			
9110	Palliative (emergency) treatment of dental pain - minor procedures.		[32]

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510	Inlay, metallic - one surface (excluding gold).	[147]
2520	Inlay, metallic - two surfaces (excluding gold).	[171]
2530	Inlay, metallic - three surfaces (excluding gold).	[204]

Crowns - Single Restorations Only

2710	Crown - Plastic (acrylic).	[50]
2721	Crown - resin with predominantly base metal.	[95]
2740	Crown - porcelain/ceramic substrate. [250]	
2752	Crown - porcelain fused with noble metal.	[224]
2810	Crown - 3/4 cast metallic.	[250]
2830	Crown - Stainless steel.	[275]

[Oral Surgery]

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal lap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]

Vestibuloplasty

7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
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Surgical Incision

7510	Incision and drainage of abscess - intraoral soft tissue.	[50]]
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[Endodontics]

Pulp Capping

3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]

Pulpotomy

3220	Therapeutic pulpotomy (excluding final restoration).	[63]
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Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)

3310	One canal (excluding final restoration).	\$[265]
3320	Two canals (excluding final restoration).	[324]
3330	Three canals (excluding final restoration).	[418]
3340	Four or more canals (excluding final restoration).	[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]

Periapical Services

3410	Apicoectomy (per tooth) - first root.	[248]]
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[Periodontics**Surgical Services (Including Unusual Postoperative Services)**

4210	Gingivectomy or gingivoplasty - per quadrant.	[105]
4211	Gingivectomy or gingivoplasty - per tooth.	[63]
4220	Gingival curettage, by report.	[42]
4240	Gingival flap curettage (including root planning).	[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]

Adjunctive Periodontal Services

4340	Root Planning - entire mouth.	[296]
4341	Root Planning - per quadrant.	[74]
4910	Periodontal Prophylaxis.	[42]]

Prosthodontics (Removable)**Complete Dentures (Including Routine Post Delivery Care)**

5110	Complete upper.	[261]
5120	Complete lower.	[259]
5130	Immediate upper.	[289]
5140	Immediate lower.	[277]

Partial Dentures (Including Routine Post Delivery Care)

5211	Upper partial - acrylic base (including any conventional clasps and rests).	[313]
5212	Lower partial - acrylic base (including any conventional clasps and rests).	[315]
5213	Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).	[236]
5214	Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).	[236]
5216	Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).	[315]
5281	Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).	[126]

Adjustments to Dentures

5410	Adjust complete denture - upper (more than six months after installation).	[15]
5411	Adjust complete denture - lower (more than six months after installation).	\$ [16]
5421	Adjust partial denture - upper (more than six months after installation).	[14]
5422	Adjust partial denture - lower (more than six months after installation).	[15]

Repairs to Dentures

5520	Replace missing or broken teeth - complete denture (each tooth)	[42]
5640	Replace broken teeth or denture, no other repairs.	[46]
5650	Add tooth to existing partial denture.	[67]
5660	Add clasp to existing partial denture.	[75]

Denture Reline Procedures

5730	Reline complete upper denture (chair side).	[58]
5731	Reline complete lower denture (chair side).	[66]
5740	Reline upper partial denture (chair side).	[63]
5741	Reline lower partial denture (chair side).	[63]
5750	Reline complete upper denture (laboratory).	[81]
5751	Reline complete lower denture (laboratory).	[82]
5760	Reline upper partial denture (laboratory).	[84]
5761	Reline lower partial denture (laboratory).	[79]

Other Removable Prosthetic Services

5820	Temporary partial - stayplate denture (upper).	[193]
5821	Temporary partial - stayplate denture (lower).	[205]

Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)

Bridge Pontics

6211	Pontic - cast predominantly base metal.	[197]
6241	Pontic - porcelain fused to predominantly base metal.	[210]
6251	Pontic - resin with predominantly base metal.	[213]

Bridge Retainers - Crowns

6710	Crown - resin.	[160]
6721	Crown - resin with predominantly base metal.	[171]
6751	Crown - porcelain fused to predominantly base metal.	[210]
6791	Crown - full cast predominantly base metal.	[208]

Other Fixed Prosthetic Services

6930	Recement bridge.	[42]
6940	Stress breaker.	[101]

Orthodontics (No Scheduled Maximums)

Minor treatment for tooth guidance

8110	Upper retainer.
8112	Lower retainer.
8120	Fixed appliance therapy.

Minor treatment to control harmful habits

8210	Removable appliance therapy.
8220	Fixed appliance therapy.

Interceptive orthodontic treatment

8360	Removable appliance therapy.
8370	Fixed appliance therapy.

Comprehensive orthodontic treatment-transitional dentition

- 8460 Class I malocclusion.
- 8470 Class II malocclusion.
- 8480 Class III malocclusion.

Comprehensive orthodontic treatment-permanent dentition

- 8560 Class I malocclusion.
- 8570 Class II malocclusion.
- 8580 Class III malocclusion.

Other orthodontic procedures

- 8650 Treatment of the atypical or extended skeletal case.
- 8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

- 9220 General anesthesia. \$ [116]

Monitor Life Insurance Company of New York

Dental Care Plan

[Doe & Doe, Ltd.]

Group Number: [25-1371]

Effective Date: [January 1, 2011]

Monitor Life Insurance Company of New York

70 Genesee Street
Utica, New York 13502
Telephone 800-422-6200

(Herein called the Company)

Certificate of Insurance of Your Group Dental Program

This booklet is a summary of your group dental program. Please read it carefully. It only summarizes the detailed provisions of the group dental contract issued by **Monitor Life Insurance Company of New York** ("Monitor") and cannot modify the Contract in any way.

President
Monitor Life Insurance Company of New York

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Monitor Life Insurance Company of New York

Group Highlights

Applicant Name: [Doe & Doe, Ltd.]

Address: [P. O. Box 14000]
[Utica, New York 13502]

Group Number: [25-1271]

Effective Date: [January 1, 2011]

Contract Term: [January 1, 2011 through December 31, 2011]

Minimum Number of Hours: [20 hours per week]

Eligibility Period: [Three (3) months]

Effective Day of Month: [First day of the month following completion of eligibility]

Open Enrollment Period: [January]

Premiums

Monthly Amount:

For each Primary Enrollee: [\$19.87]

For each Primary Enrollee with
One Dependent Enrollee [\$39.71]

For each Primary Enrollee with more than
One Dependent Enrollee [\$59.73]

Payment Breakdown:

Primary Enrollee shall pay [100%] of Premiums for personal coverage. Primary Enrollee shall pay [100%] of Premiums for Dependent coverage.

Applicant may charge person electing continued coverage pursuant to Title X of P. L. 99 as permitted by law.

Premium Basis

Premiums are based on the number of covered Primary Enrollees at the beginning of each contract term.

A 15% reduction in the number of Primary Enrollees over 3 consecutive months in a contract term, may affect the premium.

Benefits:

	Policy Year		
	1	2	3+
Type I Procedures (Diagnostic & Preventive Benefits)	[80%]	[90%]	[100%]
Type II Procedures (Basic Benefits)			
Preventative	[60%]	[70%]	[80%]
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Restorative	[60%]	[70%]	[80%]
Palliative	[60%]	[70%]	[80%]
Type III Procedures			
[Oral Surgery	[60%]	[70%]	[80%]
[Endodontics	[0%]	[40%]	[50%]
[Periodontics	[0%]	[40%]	[50%]
Prosthodontics (Removable & Fixed)	[0%]	[40%]	[50%]
Orthodontics	[0%]	[40%]	[50%]

These percentages are based on the Contract Allowance.

Note - Procedures subject to the waiting period are not covered and do not apply toward the deductible during the waiting period.

Waiting Periods:

Type I Procedures	[0 months]
Type II Procedures	[0 months]
Type III Procedures	[12 months]

Orthodontic Benefits are limited to Dependent Enrollee children six (6) years to age 19.

Deductible Amount

For each Enrollee	[\$100.00 for the term of each Enrollee's policy per [Contract Year]]
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Any deductible for Orthodontic Benefits an Enrollee satisfied under the Applicant's prior plan will be credited toward the deductible under this plan.

Maximum Amount:

[\$600.00] per Enrollee per [Contract Year] for Prosthodontic Benefits.
[\$350.00] per Enrollee per [Contract Year] for Orthodontic Benefits.
[\$1,000.00] per Enrollee per Lifetime for Orthodontic Benefits.
[\$1,000.00] per Enrollee per [Contract Year] for All Benefits (Type I, II, & III Combined)
[\$500.00] per Enrollee age 65 or older per [Calendar Year] for Prosthetics or the repair thereof.]

Monitor will receive credit for any amount paid for Orthodontic Benefits only under the Applicant's previous dental care plan for the same or similar benefits. These amounts will be credited towards the maximum amounts payable for Orthodontic Benefits.

Termination:

Less than [Ten (10)] Primary Enrollee(s).

State of Issue: [New York]

Definitions

Terms when capitalized in this document have defined meanings, given either in the section below or within the contract sections.

- 1.01 **“Applicant”** – the employer, association or other organization or group contracting to obtain Benefits.
- 1.02 **“Approved Amount”** – the total fee chargeable for a Single Procedure.
- 1.03 **“Attending Dentist’s Statement”** – the standard form used to file a claim or request Predetermination of Benefits provided under the Contract.
- 1.04 **“Benefits”** – the amounts that Monitor will pay for dental services under Article 4.
- 1.05 **“Calendar Year”** – the 12 months of the year from January 1 through December 31.
- 1.06 **“Contract”** – this agreement between Monitor and Applicant, including the Application and the attachments listed in Article 9.
- 1.07 **“Contract Allowance”** – the maximum amount allowed for a Single Procedure. It is the lesser of the Dentist’s submitted fee, and the Scheduled Maximum, if any, and the Dentist’s fee filed with Monitor in the Participating Dentist Agreement, if any, or the UCR.
- 1.08 **“Contract Term”** – the period during which the Contract is in effect, as shown in the Group Highlights page.
- 1.09 **“Contract Year”** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter. Deductibles and maximums will be determined using this 12 month period rather than on a calendar year basis.
- 1.10 **“Dentist”** – a person licensed to practice dentistry when and where services are performed.
- 1.11 **“Dependent Enrollee”** – an Eligible Dependent enrolled in the plan to receive Benefits.
- 1.12 **“Effective Date”** – the date the program starts, as shown in the Group Highlights page.
- 1.13 **“Eligible Dependent”** – a dependent of an Eligible Person eligible for Benefits under Article 2.
- 1.14 **“Eligible Person”** – a person as listed in the Group Highlights page, designated by the Applicant as eligible for Benefits under Article 2.
- 1.15 **“Enrollee”** – an Eligible Person (“Primary Enrollee”) or an Eligible Dependent (“Dependent Enrollee”) enrolled to receive Benefits.
- 1.16 **“Non-Preferred, Non-Network, Non-Contracting, Non-Participating Dentist”** – a Dentist who has not agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor

contracts to assist it in administering the Benefits described in this Contract. A Non-Participating Dentist may charge more than the Contract Allowance. The fee allowed for Non-Participating Dentists is the fee agreed to by Participating Dentists. See Participating Dentist.

- 1.17 **“Open Enrollment Period”** – the month(s) of the year, as shown in the Group Highlights page, during which Eligible Persons may change coverage for the next [Contract year].
- 1.18 **“Predetermination”** – Monitor shall estimate the amount of Benefits under the Contract for the services proposed, assuming the patient is eligible.
- 1.19 **“Preferred, Network, Contracting, Participating Dentist”** – a Dentist who in executing a Participating Dentist Agreement has agreed to provide services in accordance with the terms and conditions established by Monitor and any member of the Monitor Dental Plans Association with which Monitor contracts to assist it in administering the Benefits described in this Contract. Participating Dentists have agreed to charge no more than the Contract Allowance. See Non-Participating Dentist.
- 1.20 **“Premiums”** – the amounts payable monthly by the Applicant as required in the Contract.
- 1.21 **“Primary Enrollee”** – an Eligible Person enrolled in the plan to receive Benefits.
- 1.22 **“Procedure Number”** – the number given to a Single Procedure in the Monitor Dental Uniform Procedure Code and Nomenclature attached as Appendix A.
- 1.23 **“Qualifying Family Status Change”** – a change which occurs as a result of i) marriage, divorce or legal separation; ii) a child’s birth or adoption; iii) a change in spouse’s employment; iv) a death in the family; v) a court order requiring dependent coverage; or vi) termination of employment.
- 1.24 **“Scheduled Maximum”** – the maximum Contract Allowance for each dental procedure, as shown in Appendix A, if any.
- 1.25 **“Single Procedure”** – a dental procedure that is assigned a separate Procedure Number. For example: a single x-ray file (Procedure 0220), or a complete upper denture (Procedure Number 5110).
- 1.26 **“UCR”** – “usual, customary and reasonable” which have the following meanings:

Usual – A “usual” fee is that fee regularly charged and received for a given service by an individual Dentist, i.e., his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

Customary – a fee is “customary” when it is within the range of usual fees charged and received by Dentists of similar training for the same service within the geographic areas determined by Monitor to be relevant. Customary fees may be determined on the basis of fees filed with Monitor by Participating Dentist. A Customary fee for a Participating Dentist is that fee which is approved by Monitor in the terms of the Participating Dentist Agreement.

Reasonable – A fee is “reasonable” if it is “usual” and “customary” or if it falls above “usual” and “customary” or both, but is determined to be justifiable considering the special circumstances or extraordinary difficulty of the case in question.

- 1.27 **“Uniform Procedure Code”** – the Monitor Uniform Procedure Code and Nomenclature, which is attached to and made a part of the Contract.
- 1.28 **“We, Our, or Us”** – Monitor, and will be used without respect to capitalization.
- 1.29 **“You, Your, Yours”** – the Primary Enrollee and will be used without respect to capitalization.

Choice of Dentist

Monitor offers you a choice of selecting a Dentist from our panel of Participating Dentists, if applicable, or you may choose a Non-participating Dentist.

A directory of Participating Dentists is available from your employer. You are responsible for verifying whether the Dentist you select is a Participating Dentist. Dentists are regularly added to the panel so a Participating Dentist may not yet be listed. Additionally, you should always confirm that a listed Dentist is still a Participating Dentist.

You may choose to go to any Dentist. Even if you choose a Participating Dentist from our panel, Monitor cannot guarantee that a particular Dentist will be available.

There may be a difference in the out-of-pocket cost you pay if your Dentist is not a Participating Dentist. A Participating Dentist has contractually agreed not to charge you any amount for services above the Contract Allowance. We pay your Benefits based on the Contract Allowance less any deductibles or maximums that may apply.

If a Dentist is not a Participating Dentist, the amount charged to you may be above that charged by our Participating Dentists. When we pay Benefits for services provided by Non-participating Dentists, we will allow the Contract Allowance, or the fee paid to Participating Dentists. You will then be responsible for any extra amount charged by this Dentist over what Benefits we will pay in addition to any deductibles and maximums specified by the plan. This is called balance billing, that is, the Dentist may bill you for the balance after Monitor’s payment is made.

Who Is Eligible?

Eligibility for Enrollment

All present, permanent employees working the minimum number of hours per week shown on the Group Highlights page are eligible on the Effective Date.

All future, permanent employees shall become eligible on the calendar day of the month shown on the Group Highlights page after they have worked full-time for the minimum number of months of continuous employment shown on the Group Highlights page.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents.

Dependents are your:

- a) Lawful spouse;
- b) Unmarried dependent children from birth to their 19th birthday, or 25th birthday, if a full-time student in an accredited school.

“Children” includes natural children, stepchildren, adopted children and foster children. The child must be dependent on the Eligible Person for support. Newborn infants are eligible from the moment of birth. Adopted children are eligible from the moment of placement in the physical custody of the Eligible Person, as certified by the agency making the placement. A child shall automatically be covered for 31 days after birth or adoption placement. To continue coverage after 31 days, notice of the birth or placement and additional Premium, if any, must be received within the 31-day period.

An unmarried child 19 years or older may continue to be eligible as a dependent if the child is:

- a) Not self-supporting because of mental incapacity or physical handicap that began before age 19, and
- b) The child must be mostly dependent on the Eligible Person for support and maintenance.

Proof of these facts must be given to Monitor or your employer within 31 days if it is requested. Proof will not be required more than once a year after the child is 21.

Dependents in military service are not eligible.

Enrollment Requirements

If you are paying all or a portion of premiums for yourself or your dependents then:

- a) You must enroll within 30 days after the date you become eligible or during an Open Enrollment Period.
- b) All dependents must be enrolled within 30 days after they become eligible or during an Open Enrollment Period.
- c) If you elect dependent coverage, you must enroll all of your Eligible Dependents for coverage.
- d) You pay Premiums for Dependent Enrollees in the manner elected by your employer and approved by Monitor until your dependents are no longer eligible or until you choose to drop dependent coverage. Coverage may not be dropped or changed at any time other than during an Open Enrollment Period or if there is a Qualifying Family Status Change.
- e) If both you and your spouse are Eligible Persons, one of you may enroll as a Dependent Enrollee of the other. Dependent children may enroll as Dependent Enrollees of only one Primary Enrollee.

Loss of Eligibility

Your coverage ends on the last day of the month you stop working for your employer, or immediately when this program ends. Your dependents' coverage ends when your coverage ends, or as soon as they are no longer dependents as defined in this certificate.

Continuation of Benefits

Monitor does not pay Benefits for services received after your coverage ends. But Monitor will pay for Single Procedures started before that date.

Strike, Lay-off and Leave of Absence

You and your dependents will not be covered for any dental services received while you are on strike, lay-off or leave of absence, other than as required under the Family Medical Leave Act of 1993*. If you return to work within six (6) months you will become eligible on the first day of the month following your return. If you are gone more than six (6) months, you will have to re-qualify for coverage just like a new employee. No matter when you return, any deductibles and maximums will start over, just like a new employee.

*You and your dependents' coverage is not affected if you take a leave of absence allowed under the Family Leave Act of 1993. If you are currently paying any part of your premium, you may choose to continue coverage. If you do not continue coverage during the leave, you can resume that coverage on your return to active work as if no interruption occurred. **Important:** The Family Medical Leave Act does **not** apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

Optional Continuation of Coverage (COBRA)

When the Eligible Persons of the employer are covered under the Consolidated Omnibus Budget Reconciliation Act of 1986, then in consideration of the premium payments, Monitor agrees to provide Benefits to Enrollees who elect continued coverage pursuant to this section.

- a) Right to Continue. Coverage may continue in accordance with the following provisions when:
- (1) You or your Dependent Enrollee becomes ineligible for coverage under the Contract due to a Qualifying Event shown below; and
 - (2) The Contract remains in force.

"Qualifying Event" means one of the following events, if it would otherwise result in a Qualified COBRA Beneficiary's loss of coverage under this Contract:

- (1) Your termination of employment.
- (2) Your death.
- (3) Divorce or legal separation from you.
- (4) You becoming entitled to Medicare benefits.

- (5) A dependent child ceasing to meet the description of a dependent child.
- (6) A bankruptcy proceeding under Title 11, United States Code with respect to the employer, which results in a substantial elimination of coverage (within one year before or one year after the date of commencement of the proceeding) of a retired Primary Enrollee (who retired on or before the date of substantial elimination of coverage), or of a Dependent Enrollee of a retired Primary Enrollee.

“Qualified Beneficiary” means you and any of your Dependent Enrollees who are entitled to continue coverage under the Contract, from the date of your first Qualifying Event. It also includes your natural child, legally adopted child or child placed for the purpose of adoption; when the new child:

- (1) Is acquired during your 18 or 29 month continuation period; and
- (2) Is enrolled for coverage in accordance with the terms of the Contract.

But it does not include your new spouse, stepchild or foster child acquired during the continuation period: whether or not the new Dependent is enrolled for coverage.

b) Continuation Periods. The maximum period of continued coverage for each Qualifying Event shall be as follows:

- (1) Termination of Employment. When eligibility ends due to your termination of employment; then coverage for you and any of your Dependent Enrollees may be continued for up to 18 months from the date employment ended. Termination of employment includes a reduction in hours or retirement.

Exceptions:

- (i) Misconduct. If your termination of employment is for gross misconduct, coverage may not be continued for you or any of your Dependent Enrollees.
- (ii) Disability. “Disability” or “Disabled” as used in this section shall be defined by Title II or XVI of the Social Security Act and determined by the Social Security Administration.

If you:

- (a) Become disabled by the 60th day after your employment ends; and
- (b) Are covered for Social Security Disability Income benefits; then coverage for you and any of your Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

If your Dependent Enrollee:

- (a) Becomes disabled by the 60th day after your employment ends; and
- (b) Is covered for Social Security Disability Income benefits; then coverage for that Dependent Enrollee may be continued for up to 29 months, from the date your employment ended.

You must send the employer a copy of the Social Security Administration's letter:

- (a) Within 60 days after they find that you or your Dependent Enrollee is disabled, and before the 18 month continuation period expires; and again
- (b) Within 30 days after they find that he or she is no longer disabled.

(iii) Subsequent Qualifying Event. If your Dependent:

- (a) Is a Qualified Beneficiary; and
- (b) Has a subsequent Qualifying Event during the 18 or 29 month continuation period; then coverage for that Dependent Enrollee may be continued for up to 36 months, from the date your employment ended.

(2) Loss of Dependent Eligibility. If a Dependent Enrollee's eligibility ends, due to a Qualifying Event other than your termination of employment; then that Dependent Enrollee's coverage may be continued for up to 36 months, from the date of the event. Such events may include:

- (i) Your death, divorce, legal separation, or Medicare entitlement; and
- (ii) A child reaching the age limit, getting married or ceasing to be a full-time student.

You must notify the employer within 60 days of divorce, a legal separation, or a child ceasing to be an eligible Dependent (as defined by the Contract). One or more subsequent Qualifying Events may occur during the Dependent Enrollee's 36 month period of continued coverage; but coverage may not be continued beyond 36 months, from the date of the first event.

(3) Medicare Entitlement. If your eligibility under the Contract ends when you become entitled to Medicare benefits; then coverage may not be continued for yourself. But coverage may be continued for any of your Dependent Enrollees for up to thirty-six (36) months, from your Medicare entitlement date.

If your eligibility under the Contract continues beyond Medicare entitlement, but later ends upon termination of employment or retirement; then any of your Dependent Enrollees may continue coverage for up to:

- (i) 36 months from your Medicare entitlement date; or
- (ii) 18 months from the date your employment ended (whichever is later).

c) Election. To continue coverage, you must notify the employer of such election within 60 days from the later of:

- (1) The date of the Qualifying Event;
- (2) The date of the loss of coverage; or
- (3) The date the employer sends notice of the right to continue.

Continued coverage elected under this section shall be effective the first day of the month following the applicable Qualifying Event. However, Benefits shall not be available to a person electing continuation until Monitor receives the data about such person required in the Contract, along with all Premiums then currently payable for such person. Monitor shall not, in any event, make benefits available under this section with respect to any person for whom such information and Premium are not received by Monitor within 60 days after the date such person is required to notify the employer of his or her election as stated above.

- d) Termination. Continued coverage will end at the earliest of the following dates:
- (1) The end of the maximum period for continued coverage shown above;
 - (2) The date the Contract terminates;
 - (3) The last day of the period for which Premium has been paid; if any Premium is not paid when due;
 - (4) The date you or your Dependent Enrollee:
 - (i) Becomes covered under any other group dental plan; or
 - (ii) Become eligible for benefits for Medicare.

Once continued coverage ends; it cannot be reinstated.

Deductible

Your dental plan features a deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The deductible amounts are listed on the Group Highlights page.

Only the Dentist's fees you pay for covered Benefits will count toward the deductible.

Maximum Amount

The Maximum Amount payable is shown on the Group Highlights page. There may be maximums on a yearly basis, a per services basis, or a lifetime basis.

Monitor will receive credit for any amounts paid for Orthodontic Benefits. Those amounts shall be deducted from the maximum paid by Monitor.

However, Orthodontic Benefits, if provided, will end with the next payment due although the maximum has not been reached if the patient loses coverage, if treatment is stopped, or if the Contract with your employer is cancelled.

Premiums

You will be responsible for [100%] of the cost of premiums for yourself. You will be responsible for [100%] of the cost of premiums for your Dependent Enrollees.

Monitor may cancel this Program 30 days after written notice to your employer if monthly Premiums are not paid when due.

Benefits, Limitations & Exclusions

Subject to the limitations and exclusions in this Contract, Monitor shall pay the Benefits for each type of dental service described below when provided by a Dentist and when necessary and customary under generally accepted dental practice standards. Monitor may use dental consultants to determine generally accepted dental practice standards. Eligibility periods, if any, for specific services are shown in Group Highlights.

Patient Copayment - Monitor's provision of Benefits is limited to the applicable percentage of Dentist's fees specified in Group Highlights. The Enrollee is responsible for paying the remaining applicable percentage of any such fees, known as the "Patient Copayment". Applicant has chosen to require Patient Copayments under this program as a method of sharing the costs of providing dental Benefits between Applicant and Enrollees. If the Dentist discounts, waives or rebates any portion of the Patient Copayment to the Enrollee, Monitor shall be obligated to provide as Benefits only the applicable percentages of the Dentist's fees as reduced by the amount of such fees or allowances that is discounted, waived or rebated.

Limitations on All Benefits – Optional Services. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example: a crown where a filling could restore the tooth or an inlay instead of a restoration. If an Enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

No change in Benefits will become effective during a Contract Term unless Applicant and Monitor agree in writing.

Exclusions - Monitor does not pay Benefits for:

- a) Treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- b) Cosmetic surgery or procedures for purely cosmetic reasons, or services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).

- c) Treatment to restore tooth structure lost from wear, erosion, or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize teeth. For example; equilibration, periodontal splinting, occlusal adjustment.
- d) Any Single Procedure started before the patient is covered under this program.
- e) Prescribed drugs, medication or painkillers.
- f) Experimental procedures.
- g) Charges by any hospital or surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) Services for any disturbance of the temporomandibular joints (jaw joints).
- k) Treatment by someone other than a Dentist or a person who by law may work under a Dentist's direct supervision.
- l) For services provided outside the United States, its territories, or possessions, other than emergency dental treatment, unless the Primary Enrollee resides outside the United States, its territories, or possessions.
- m) The initial installation of a fixed bridge or partial denture is not a benefit unless the bridge or denture is made necessary by natural teeth extraction occurring during a time the patient was eligible under this dental plan.

Diagnostic and Preventive Benefits (Type I Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Diagnostic: procedures to aid the Dentist in choosing required dental treatment.

Preventive: prophylaxis (cleaning; periodontal scaling in the presence of inflamed gums is considered to be a Basic Service for payment provisions); topical application of fluoride solutions; sealants (topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in teeth for the purpose of preventing decay).

Limitations on Diagnostic and Preventive Benefits (Type I Procedures)

- a) Monitor will not pay for more than one (1) cleaning, including periodontal cleanings, done in any six (6) month period that the Enrollee is covered by any Monitor program.

- b) Monitor will not pay for more than one (1) oral exam done in any six (6) month period that the Enrollee is covered by any Monitor program.
- c) Full-mouth x-rays or panoramic x-rays will be provided when required by the Dentist, but no more than one set each 36-month period will be paid by Monitor.
- d) Bitewing x-rays are limited to one (1) set each twelve (12) months period.
- e) Topical applications of fluoride are limited to one (1) each twelve (12) month period when provided to Enrollees under age 19; furthermore, Monitor will not pay for topical application of fluoride for an Enrollee 19 years of older.
- f) Sealant applications to any one posterior permanent tooth are limited to one (1) each 36-month period.

Basic Benefits (Type II Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

Preventative:	space maintainers.
[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Restorative:	Amalgam (including polishing), silicate restorations, filled or unfilled resin restorations and other restorative services
Palliative:	treatment to relieve pain.

Limitations on Basic Benefits (Type II Procedures) - Monitor will not pay for space maintainers for baby teeth for an Enrollee 16 years or older.

Major Benefits (Type III Procedures) - Monitor shall pay or otherwise discharge the percentage shown in the Group Highlights page of the Contract Allowance for the following services:

[Oral Surgery:	extractions, surgical extractions, alveoloplasty, vestibuloplasty, surgical incision, and other surgical procedures.]
[Endodontics:	pulp capping, pulpotomy, root canal therapy, and periapical services.]
[Periodontics:	surgical services (including unusual postoperative services) and adjunctive periodontal services.]
Prosthodontics:	Complete & partial dentures (including routine post delivery care), adjustments to dentures, repairs to dentures, denture reline procedures, other removable

prosthetic devices, bridge pontics, bridge retainers – crowns, and other fixed prosthetic services.

Orthodontics: The procedures performed by a Dentist using appliances to treat poor alignment of teeth and/or jaws which significantly interferes with their function.

Limitations on Prosthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] is shown in Group Highlights.
- b) Monitor will not pay to replace any crown, jacket or cast restoration, which the patient received in the previous five (5) years.
- c) Monitor will not pay to replace any bridge or denture that the patient received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.
- d) Monitor limits Benefits for dentures to a standard partial or complete denture. A “standard” denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.
- e) Monitor will not pay for implants (artificial teeth implanted into or on bone or gums) or their removal; but Monitor will credit the cost of a standard complete or partial denture that would have been allowed under this plan toward the cost of an implant and related services (copayments apply.)

Limitations on Orthodontic Benefits

- a) The maximum amount paid by Monitor for each Enrollee during the [Contract year] and Enrollee’s lifetime is shown in Group Highlights.
- b) Payment of Orthodontics is provided monthly.
- c) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
- d) Benefits end with the next payment due after the loss of coverage. Benefits end immediately if treatment stops or if this Contract is terminated.
- e) Benefits are not paid to repair or replace any orthodontic appliance received under this Contract.
- f) X-rays or extractions are not subject to the Orthodontic maximum.
- g) Surgical procedures are not subject to the Orthodontic maximum.
- h) Orthodontic Benefits are limited to Dependent Enrollees within the ages shown in Group Highlights.

- i) Orthodontic Benefits are limited to Dependent Children who have been enrolled in this plan for [12] consecutive months. This provision will be waived for Eligible Persons and their Eligible Dependents who were enrolled in the Applicant's previous plan.

Coordination of Benefits

Monitor matches the Benefits under this program with your benefits under any other group pre-paid program or benefit plan. (This does not apply to a blanket school accident policy). Benefits under one of the programs may be reduced so that combined coverage does not exceed the Dentist's fees for covered services. If this is the "primary" program, Monitor shall not reduce Benefits. But if the other program is the primary one, Monitor shall reduce Benefits otherwise payable under this program. The reduction shall be the amount paid for or provided under the terms of the primary program for covered services under this program (see BENEFITS, LIMITATIONS & EXCLUSIONS).

How does Monitor determine which is the "primary" program?

- a) If the other program is not primarily a dental program, this program is primary.
- b) If the other program is a dental program, the following rules are applied:
 - (1) The program covering the patient as an employee or group member is primary over a program covering the patient as a dependent.
 - (2) The plan covering the patient as a dependent child of a person whose date of birth occurs earlier in the calendar year shall be primary over the plan covering the patient as a dependent of a person whose date of birth occurs later in the calendar year provided. However, in the case of a dependent child of legally separated or divorced parents, the plan covering the patient as a dependent of the parent with legal custody, or as a dependent of the custodial parent's spouse (i.e. step-parent) shall be primary over the plan covering the patient as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other policy which covers the child as a dependent child.
- c) If neither (a) nor (b) applies, the program that has covered the patient longer is primary, except that a plan covering the patient as a laid-off or retired employee or the dependent of a laid-off or retired employee shall be determined after those of a plan covering the patient as an employee or the dependent of an employee. However, if the other plan does not have a provision similar to this provision, then this exception shall not apply.

Claims

Claims for Benefits must be filed on a standard Attending Dentist Statement that you or your Dentist may obtain from:

Monitor Life Insurance Company of New York
Attn: Membership Services
P.O. Box 16708
Jackson, Mississippi 39236
(800) 800-1397

Claims not paid within 45 days of due written proof of loss are subject to a charge of 1 and ½ percent interest per month.

Predeterminations

A Dentist may file an Attending Dentist's Statement before treatment, showing the services to be provided to an Enrollee. Monitor will predetermine the amount of Benefits payable under this Contract for the listed services. Predeterminations are valid for 60 days from the date of the Predetermination but not longer than the Contract's term or beyond the date of the patient's coverage ends.

Claims Appeal

Monitor will notify the Enrollee if any services submitted on a claim are denied coverage as Benefits, in whole or in part, stating the reason or reasons for the denial. Within 60 days after the receipt of a notice of denial the Enrollee may make a written request for a review of the denial by addressing a letter to Monitor stating the reason(s) for review or reconsideration and providing any pertinent documents which the Enrollee wishes Monitor to review.

Monitor will make a full and fair review. Monitor may ask for more documents if needed. Some appeals may be referred to a dental consultant or to a peer review committee of your local dental society. A decision will be sent to the Primary Enrollee within 30 days after your request for an appeal is received, unless it is referred to a peer review committee or other unusual circumstances arise. In no event will the decision take longer than 120 days.

Cancellation of Program

Monitor may cancel the program only:

- a) On an anniversary of the Effective Date; or
- b) If your employer does not pay the monthly premiums; or
- c) If your employer does not provide a list of who is eligible; or
- d) If less than the minimum number of Primary Enrollees required under the Contract reported eligible for three months or more.

Proof of Loss

Before approving a claim, Monitor will be entitled to receive, to such extent as may be lawful, from any attending or examining Dentist, or from hospitals in which a Dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an Enrollee as may be required to administer the claim, or that an Enrollee be examined by a dental consultant retained by Monitor, in or near his community or residence. Monitor shall in every case hold such information and records confidential.

Monitor will give any Dentist or Enrollee, on request, a standard Attending Dentist's Statement to make a claim for Benefits. To make a claim, the form must be completed and signed by the Dentist who performed the services and by the Enrollee (or the parent or guardian if the patient is a minor) and submitted to Monitor. If the form is not furnished by Monitor within 15 days after requested by a Dentist or Enrollee, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to Monitor, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Affirmative proof of loss must be furnished to Monitor at its office within 90 days after termination of care for which Benefits are payable hereunder. Failure to furnish proof of loss within that time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof of loss and that such proof of loss was furnished as soon as was reasonably possible.

Time of Payment

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss.

Subject to due written proof of loss, all accrued indemnities for loss which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payments will be made within 45 days if any claim is not denied for valid and proper reasons within 45 days after receipt of due written proof. The Company pays interest at the rate of 1 and ½ percent per month on the amount of the claim until it is finally settled or adjudicated. If the Company does not pay a claim when due, the insured may bring action to recover benefits and any other damages.

To Whom Benefits are Paid

Payment for services provided by a Participating Dentist shall be made directly to the Dentist. Any other payments provided by this Contract shall be made to the Primary Enrollee, unless the Primary Enrollee requests when filing proof of loss that the payment be made directly to the Dentist providing the services. All Benefits not paid to the Dentist shall be payable to the Primary Enrollee, or to his estate, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his parent, guardian or to their person actually supporting him.

Legal Actions

No action at law or in equity shall be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract, nor shall an action be brought at all unless brought within 3 years from expiration of the time within proof of loss is required by the Contract.

This Certificate of Insurance constitutes only a summary of the dental service insurance Contract. The complete Contract must be consulted to determine the exact terms and conditions of coverage.

APPENDIX A

MONITOR UNIFORM PROCEDURE CODE AND NOMENCLATURE

The following is a Complete list of the dental procedures for which benefits are payable under this Certificate and each procedure's Schedule Maximum, if any. No benefits are payable for a procedure if it is not listed.

DIAGNOSTIC AND PREVENTIVE (TYPE I PROCEDURES)

Diagnostic

Clinical Oral Examinations

0120	Periodic oral examination.	\$	[21]
0130	Emergency oral examination.		[21]

Radiographs

0210	Intraoral - complete series (including bitewings).	[50]
0220	Intraoral periapical - first film.	[10]
0230	Intraoral periapical - each additional film up to 12.	[6]
0240	Intraoral - occlusal film.	[11]
0250	Extraoral - first film.	[10]
0260	Extraoral - each additional film.	[13]
0270	Bitewing - single films.	[12]
0272	Bitewings - two films.	[16]
0274	Bitewings - four films.	[22]
0330	Panographic film.	[44]

Tests and Laboratory Examinations

0470	Diagnostic cast.	[40]
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Preventive

Dental Prophylaxis

1110	Prophylaxis - adult.	[32]
1120	Prophylaxis - child.	[26]

Topical Fluoride Treatment (Office Procedure)

1201	Topical application of fluoride (including prophylaxis) - child.	[38]
1202	Topical application of fluoride (including prophylaxis) - adult.	[44]
1203	Topical application of fluoride (excluding prophylaxis) - child.	[13]
1204	Topical application of fluoride (excluding prophylaxis) - adult.	[13]

Other Preventive Services

1351	Sealant - per tooth.	[16]
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BASIC BENEFITS (TYPE II PROCEDURES)

Preventive

Space Maintenance (Passive Appliances)

1510	Space Maintainer - fixed unilateral.	\$	[131]
1515	Space Maintainer - fixed-bilateral.		[231]
1520	Space Maintainer - removable-unilateral.		[170]
1525	Space Maintainer - removable-bilateral.		[200]
1550	Recementation of space maintainer.		[32]

Restorative

Amalgam Restorations (including Polishing)

2110	Amalgam - one surface, primary.		[34]
2120	Amalgam - two surfaces, primary.		[43]
2130	Amalgam - three surfaces, primary.		[54]
2140	Amalgam - one surface, permanent.		[32]
2150	Amalgam - two surfaces, permanent.		[42]
2160	Amalgam - three surfaces, permanent.		[53]

Silicate Restorations

2210	Silicate cement - per restoration.		[21]
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Filled or Unfilled Resin Restorations

2310	Acrylic or plastic.		[30]
2330	Resin - one surface.		[37]
2331	Resin - two surface.		[47]
2332	Resin - three surfaces.		[58]

Other Restorative Services.

2940	Sedative filling.		[34]
2950	Crown buildup - pin retained.		[84]
2951	Pin retention - per tooth, in addition to restoration.		[19]
2953	Cast post as part of crown.		[144]
2954	Prefabricated post and core in addition to crown.		[125]
2970	Temporary (fractured tooth).		[84]

[Oral Surgery

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.		[38]
7120	Each additional tooth.		[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal lap and removal of bone and/or section of tooth.	[76]	
7220	Removal of impacted tooth - soft tissue.		[109]
7230	Removal of impacted tooth - partially bony.		[153]
7240	Removal of impacted tooth - completely bony.		[\$184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).		[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures			
7310	Alveoloplasty in conjunction with extractions - per quadrant.		[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.		[96]
Vestibuloplasty			
7340	Vestibuloplasty - ridge extension (secondary epithelialization).		[151]
Surgical Incision			
7510	Incision and drainage of abscess - intraoral soft tissue.		[50]]
[Endodontics			
Pulp Capping			
3110	Pulp cap - direct (excluding final restoration).		[26]
3120	Pulp cap - indirect (excluding final restoration).		[21]
Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration).		[63]
Root Canal Therapy (Including Treatment Plan, Clinical Procedures, and Follow-up Care)			
3310	One canal (excluding final restoration).	\$	[265]
3320	Two canals (excluding final restoration).		[324]
3330	Three canals (excluding final restoration).		[418]
3340	Four or more canals (excluding final restoration).		[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).		[150]
Periapical Services			
3410	Apicoectomy (per tooth) - first root.		[248]]
[Periodontics			
Surgical Services (Including Unusual Postoperative Services)			
4210	Gingivectomy or gingivoplasty - per quadrant.		[105]
4211	Gingivectomy or gingivoplasty - per tooth.		[63]
4220	Gingival curettage, by report.		[42]
4240	Gingival flap curettage (including root planning).		[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.		[315]
Adjunctive Periodontal Services			
4340	Root Planning - entire mouth.		[296]
4341	Root Planning - per quadrant.		[74]
4910	Periodontal Prophylaxis.		[42]]
Adjunctive General Services			
Unclassified Treatment			
9110	Palliative (emergency) treatment of dental pain - minor procedures.		[32]

MAJOR BENEFITS (TYPE III PROCEDURES)

Restorative

Inlay Restorations

2510	Inlay, metallic - one surface (excluding gold).	[147]
2520	Inlay, metallic - two surfaces (excluding gold).	[171]
2530	Inlay, metallic - three surfaces (excluding gold).	[204]

Crowns - Single Restorations Only

2710	Crown - Plastic (acrylic).	[50]
2721	Crown - resin with predominantly base metal.	[95]
2740	Crown - porcelain/ceramic substrate. [250]	
2752	Crown - porcelain fused with noble metal.	[224]
2810	Crown - 3/4 cast metallic.	[250]
2830	Crown - Stainless steel.	[275]

[Oral Surgery]

Extractions - Includes Local Anesthesia and Routine Postoperative Care

7110	Single tooth.	[38]
7120	Each additional tooth.	[36]

Surgical Extractions - Includes Local Anesthesia and Routine Postoperative Care

7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	[76]
7220	Removal of impacted tooth - soft tissue.	[109]
7230	Removal of impacted tooth - partially bony.	[153]
7240	Removal of impacted tooth - completely bony.	\$ [184]

Other Surgical Procedures

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).	[237]
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Alveoloplasty - Surgical Preparation of Ridge for Dentures

7310	Alveoloplasty in conjunction with extractions - per quadrant.	[76]
7320	Alveoloplasty not in conjunction with extractions - per quadrant.	[96]

Vestibuloplasty

7340	Vestibuloplasty - ridge extension (secondary epithelialization).	[151]
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Surgical Incision

7510	Incision and drainage of abscess - intraoral soft tissue.	[50]]
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[Endodontics]

Pulp Capping

3110	Pulp cap - direct (excluding final restoration).	[26]
3120	Pulp cap - indirect (excluding final restoration).	[21]

Pulpotomy

3220	Therapeutic pulpotomy (excluding final restoration).	[63]
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Root Canal Therapy (Including Treatment Plan, Clinical Procedures,

	and Follow-up Care)	
3310	One canal (excluding final restoration).	\$[265]
3320	Two canals (excluding final restoration).	[324]
3330	Three canals (excluding final restoration).	[418]
3340	Four or more canals (excluding final restoration).	[498]
3350	Apexification (treatment may extend over period of 6 to 18 months).	[150]

Periapical Services

3410	Apicoectomy (per tooth) - first root.	[248]]
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[Periodontics

Surgical Services (Including Unusual Postoperative Services)

4210	Gingivectomy or gingivoplasty - per quadrant.	[105]
4211	Gingivectomy or gingivoplasty - per tooth.	[63]
4220	Gingival curettage, by report.	[42]
4240	Gingival flap curettage (including root planning).	[158]
4260	Osseus surgery (including flap entry and closure) - per quadrant.	[315]

Adjunctive Periodontal Services

4340	Root Planning - entire mouth.	[296]
4341	Root Planning - per quadrant.	[74]
4910	Periodontal Prophylaxis.	[42]]

Prosthodontics (Removable)

Complete Dentures (Including Routine Post Delivery Care)

5110	Complete upper.	[261]
5120	Complete lower.	[259]
5130	Immediate upper.	[289]
5140	Immediate lower.	[277]

Partial Dentures (Including Routine Post Delivery Care)

5211	Upper partial - acrylic base (including any conventional clasps and rests).	[313]
5212	Lower partial - acrylic base (including any conventional clasps and rests).	[315]
5213	Upper partial - cast chrome base with acrylic saddles (including any Conventional clasps and rests).	[236]
5214	Lower partial - cast chrome base with acrylic saddles (including any conventional clasps and rests).	[236]
5216	Lower partial - cast gold base with acrylic saddles (including any conventional clasps and rests).	[315]
5281	Removable unilateral partial denture - one-piece chrome casting, clasp attachments - per unit (including pontics).	[126]

Adjustments to Dentures

5410	Adjust complete denture - upper (more than six months after installation).	[15]
5411	Adjust complete denture - lower (more than six months after installation).	\$ [16]
5421	Adjust partial denture - upper (more than six months after installation).	[14]
5422	Adjust partial denture - lower (more than six months after installation).	[15]

Repairs to Dentures

5520	Replace missing or broken teeth - complete denture (each tooth)	[42]
5640	Replace broken teeth or denture, no other repairs.	[46]

5650	Add tooth to existing partial denture.	[67]
5660	Add clasp to existing partial denture.	[75]
Denture Reline Procedures		
5730	Reline complete upper denture (chair side).	[58]
5731	Reline complete lower denture (chair side).	[66]
5740	Reline upper partial denture (chair side).	[63]
5741	Reline lower partial denture (chair side).	[63]
5750	Reline complete upper denture (laboratory).	[81]
5751	Reline complete lower denture (laboratory).	[82]
5760	Reline upper partial denture (laboratory).	[84]
5761	Reline lower partial denture (laboratory).	[79]
Other Removable Prosthetic Services		
5820	Temporary partial - stayplate denture (upper).	[193]
5821	Temporary partial - stayplate denture (lower).	[205]
Prosthodontics, Fixed (Each Abutment and Each Pontic Constitutes a Unit in a Bridge)		
Bridge Pontics		
6211	Pontic - cast predominantly base metal.	[197]
6241	Pontic - porcelain fused to predominantly base metal.	[210]
6251	Pontic - resin with predominantly base metal.	[213]
Bridge Retainers - Crowns		
6710	Crown - resin.	[160]
6721	Crown - resin with predominantly base metal.	[171]
6751	Crown - porcelain fused to predominantly base metal.	[210]
6791	Crown - full cast predominantly base metal.	[208]
Other Fixed Prosthetic Services		
6930	Recement bridge.	[42]
6940	Stress breaker.	[101]
Orthodontics (No Scheduled Maximums)		
Minor treatment for tooth guidance		
8110	Upper retainer.	
8112	Lower retainer.	
8120	Fixed appliance therapy.	
Minor treatment to control harmful habits		
8210	Removable appliance therapy.	
8220	Fixed appliance therapy.	
Interceptive orthodontic treatment		
8360	Removable appliance therapy.	
8370	Fixed appliance therapy.	
Comprehensive orthodontic treatment-transitional dentition		
8460	Class I malocclusion.	
8470	Class II malocclusion.	
8480	Class III malocclusion.	

Comprehensive orthodontic treatment-permanent dentition

- 8560 Class I malocclusion.
- 8570 Class II malocclusion.
- 8580 Class III malocclusion.

Other orthodontic procedures

- 8650 Treatment of the atypical or extended skeletal case.
- 8750 Post-treatment stabilization.

Adjunctive General Services

Anesthesia

- 9220 General anesthesia. \$ [116]